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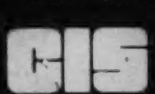

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CATASTROPHIC AND LONG-TERM HEALTH CARE

HEARINGS

BEFORE THE

COMMITTEE ON THE BUDGET
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

JUNE 1, 1987—WARREN, MI,
JUNE 22, 1987—FLINT, MI.
JUNE 29, 1987—LANSING, MI.
AUGUST 28, 1987—MARQUETTE, MI.
NOVEMBER 11, 1987—DETROIT, MI.

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CATASTROPHIC AND LONG-TERM HEALTH CARE

MONDAY, JUNE 1, 1987

U.S. SENATE,
COMMITTEE ON THE BUDGET,
Warren, MI.

The committee met, pursuant to notice, at 10:10 a.m., at the Ukrainian Cultural Center, 26601 Ryan Road, Warren, MI, Hon. Donald W. Riegle, Jr., presiding.

Present: Senator Riegle.

Staff Present: Joan M. Huffer, legislative assistant; David Krawitz, legislative director.

Senator RIEGLE. We've got a phenomenal turnout here today and I think we deserve to give everybody in this room who's come out to hear about this problem a round of applause for this kind of a turnout. This is just sensational.

I'll make a few brief opening comments about the Catastrophic Health Care Proposals that have been made first, by President Reagan to the Congress, and now by both the House and Senate committees with jurisdiction in this area. In a short time those bills will go to the floor of the House of Representatives and to the floor of the Senate where we'll have a chance to act on them.

Today we're going to discuss those proposals so that you understand what they would propose to do and where the gaps are. There are a lot of health care problems for us to face and solve as a nation, and the legislation that's being talked about just deals with part of the problem.

We're a citizen government. We build our own government, we write the laws of this country and we are a government of the people, by the people, and for the people. This meeting today is an expression of that. When there is a huge national problem and there is in the area of health care and health care cost for senior citizens it's appropriate that we meet as a citizenry, talk about these issues, decide what needs to be done, and then take the action and insist upon the action that's needed to address these problems. We should not have a country in 1987 where tens of thousands of senior citizens, who have worked a whole life time, saved money, been careful with how they've lived and so forth, who get hit with just one or two illnesses, and find their entire life's savings, they can be thrown into poverty and on to welfare through no fault of their own.

Well, we can and should do something about that. So, we're meeting here today to understand the scale of this problem and to figure out how best as a self-government system, as a group of citizens, all of us together can work to find answers to these problems.

We can do it. We can find the answers if we decide that that's important enough to do, and clearly the turnout today indicates that the overwhelming number of you that are here feel that way by your very presence.

We've got six witnesses who have prepared testimony. I'll introduce them just as we start and they will make brief presentations. I'll ask them a few questions because this is an official hearing of the Senate Budget Committee today. So, everything that we're doing here will be part of the public record. The stenographer down in front is taking down a transcript. All of this will be public so that any of you who want copies of what was said will be able to have them. We'll also be taking it back as part of the official hearing record of the Senate Budget Committee as we consider these proposals on Catastrophic Health Insurance.

After we've heard from these two panels of witnesses, I'm going to invite others in the audience to make statements. We'll have to keep them somewhat brief because I want to make sure that we can accommodate everyone.

We're going to keep this hearing going today until everybody that wants to speak has spoken and if that means until 1 o'clock, then we'll go until 1 o'clock. If it means until 3 a.m., we'll go until 3 a.m. If it means until 9 p.m. tonight then we'll be going until 9 p.m. tonight because we're going to give everybody that wants to speak a chance to do so because this is a democracy.

Mayor Bonkowski from Warren is here.

We're going to invite the Mayor to say a word or two of greeting to everybody. We're delighted he's here. He's so tall, he stands out in the crowd.

STATEMENT OF MAYOR BONKOWSKI

Mr. BONKOWSKI. Senator Riegle, I would like to take this opportunity to thank you and your staff and all the members of the Commission that are here to address this issue this morning. I do have a statement, Senator, if you would permit me, I would like to read it.

I think it's important that we at least express our opinion from the standpoint of representing such a large population of seniors in this particular area. I'm sure you're aware that our senior population is growing as it is all over the country, but we have about 38,000 in our community here and we're interested in representing their interests. I'll just take a few minutes to read my statement if I could, please.

Senator Riegle, as the Mayor of Warren, Michigan, I would like to commend you for having this hearing this morning on this extremely vital, and rapidly growing area of public concern.

As a local elected official, it can be very frustrating for me when I am unable to assist or advise my constituents who are faced with long-term illnesses which do not qualify for public or private sector financial coverage.

Senator, I realize that because of our nation's huge budget deficits, you will probably meet with resistance from some of our colleagues as you work to enact this legislation. But I hope you will

remind them, that there are areas of Federal budget that desperately need to be reexamined.

For instance, the Federal Government supports a $26 billion farm subsidy program. Seventy percent of these funds go to a mere 15 percent of the grain, cotton, and rice farmers who are supported by powerful agribusiness lobbyists in Michigan. Of course, I have no objection to the legitimate subsidies given to hard-pressed smaller farmers. But Congress has to stand up to the huge, corporate-style agricultural interests.

Another area I am concerned with is the unfair defense burden we are shouldering for the Western alliance. We are spending $100 billion to defend Western Europe, and if President Reagan thrusts us into a larger role in the Persian Gulf, our military costs will be greater yet. Our allies must provide their fair share to protect the freedoms we all cherish.

Therefore Senator, if we have the courage to take the bold steps we must take them in order to change national priorities. We as a nation can afford to provide every American with adequate health care coverage.

All of our tremendous technological advances in the medical field are meaningless if we cannot provide the actual delivery of health care to those who need it.

Senator Riegle, I want to publicly thank you for taking a leadership role on this issue of catastrophic and long-term illness funding. And I want you to know that we in the City of Warren will support you in your efforts to pass this legislation.

Thank you very much.

Senator RIEGLE. I thank the Mayor for his presence and his comments and we'll get into these issues as we go along. And I want to ask any of you that want to make a statement later on to be thinking about your thoughts.

Also, anyone who has an observation or suggestion to make or wants to tell us about problems that they see in the area of health care needs for senior citizens particularly, feel free to write that down as well.

So, if you want to talk about a problem that you've seen or a problem that you've had or somebody in your family has had, I want you to feel free to do it in that form too, if it's more comfortable to you. Because I want to make sure that everybody who has a point of view to express has a chance to express it today.

I'm now going to begin the formal meeting and I'll make these formal opening comments as we start out here.

OPENING STATEMENT OF SENATOR RIEGLE

Senator RIEGLE. Let me begin by welcoming all of you today. I want to say how much I appreciate the presence of every person. I know for some of you it was a tremendous effort to come today. I've seen people come in on walkers; I've seen people come in on wheelchairs; I've seen people come in on the arms of other people. Every person that has come today deserves the thanks of this Nation for caring enough about self-government and about these issues to be here, and I thank all of you for coming.

I want to welcome you and I want to thank the Ukrainian Cultural Center for making their facilities available to us today.

This is an official hearing of the Senate Budget Committee on the subject of Catastrophic Health Care Needs for our senior citizens. We have some very important witnesses. After they've given their testimony, we'll take statements from anyone in the audience who wishes to comment on this subject. Also, as I say, we're going to take written comments.

As most of you know who are on Medicare or are working with a family member or friend who is on Medicare, there are major gaps in the Medicare Program. Major costs can arise that Medicare will not help pay for.

Last year we spent $74 billion for the program. Despite spending all that money, we know that there were major gaps, major problems for people and we're here today to talk about how to fix those gaps.

Because of those gaps, hundreds of thousands of seniors experienced illness and who were literally driven into poverty. Their whole life savings were drained away because of one or maybe two illnesses. In the case of a couple, one person may get sick and as the bills are paid, what financial strength there is in the marriage or in the family is drawn down. The other person, who may not have an illness, is likely to get ill simply because all the money is gone and there is really no way to make ends meet. A lifetime of savings can be wiped out literally by a single major illness.

Now, this has to be changed and it can be changed. It's a question of us deciding as a Nation what's important. I'm here to say to you today with this hearing and by the actions that we're going to be taking in the Senate that this is an area that this country needs to face up to. We should not allow a situation to go on, month in and month out, year in and year out where, on a random basis tens of thousands, hundreds of thousands, probably millions of seniors are driven into poverty because of illnesses that they can't prevent. We need an insurance system in place that prevents that from happening.

That's why we're writing the law and that's why we're gathering this testimony today. I can tell you this, I'm determined to get the job done.

Now, President Reagan, to his credit has brought forward this year the issue of Catastrophic Health Insurance. He has said that this is one of the issues in the country that we're going to act on in 1987. He has his proposals and I'm going to outline some parts of that and I think we have to start there, but we're going to have to go beyond what he's recommended. But I think we should acknowledge that it's important that he has suggested that this be an area that we work on. We couldn't actually get a bill done if the President were opposed.

So, that's a positive step. Now we've got to take the ball into the Congress and we, as citizens, have to make sure we actually do the right things with the proposal. We're going to have to make the proposals stronger than what he's originally proposed.

The President has laid down two or three guidelines that we need to understand. First, he has said that if there are going to be any changes in Medicare or any new added coverage to close some

of these gaps, those changes and improvements have to be paid for by the people themselves.

In other words, by one means or another there is going to have to be a charge across the broad base of our senior citizens population to pay for those benefits. The President will not agree to any plan where the government itself spends any additional money.

He's saying that the changes in Medicare and the improvements in the coverage have to be self-financed, which means that you and I, my parents and all of us when we reach the age where we're paying for Medicare coverage, are going to have to pay the costs of broader coverage. The basic approach is to have people pay a higher monthly premium.

Many people today, in order to avoid some of these gaps in Medicare, already have private insurance coverage to back up Medicare. These are often called Medigap plans. About 65 percent of American seniors are estimated now to have these private insurance plans. Many of you in this room have them.

In fact, let's have a show of hands. How many people here presently have Medigap coverage from a private insurance company over and beyond your Social Security Medicare coverage?

[Audience complies by a show of hands.]

Senator RIEGLE. You can see just by looking around the room that a number of people do have that coverage.

The proposed changes in Medicare are designed to take care of the costs of a major illness that are not now covered by Medicare. By increasing coverage under Medicare, presumably you would not need to buy that private insurance any longer.

You might still want to buy some private insurance for some parts of the health coverage that would still not be covered by Medicare, but the major, higher cost items, the catastrophic items were you to get sick and go in the hospital for months on end, maybe with cancer or a serious heart condition, would be covered. You would not have to buy that private insurance because of the additional coverage provided by this new Catastrophic plan.

So, while you would be paying a higher premium under Medicare, you would be able to stop paying that private premium.

The benefits under the new Catastrophic proposals that we're considering would limit the out-of-pocket medical coverage services by Medicare to a maximum. The most that you would pay under Medicare under this plan that we're hoping to pass would be $1,700 a year.

Now, $1,700 a year is a lot of money. That's for the worse case. Most people would pay less than that, but that would be the limit that you would pay for a serious illness that kept you in the hospital for as long as an entire year.

Now, you have to contrast that figure. Today, people can run up medical bills of $20,000, $40,000, $60,000, $80,000; the sky is the limit. That is what we're trying to protect against.

No matter how long you needed to stay in the hospital, you would be protected. No matter how many times you needed to go to a doctor for medical treatment of an illness, you would not pay more in the course of a year than a maximum of $1,700 and as I say, that's in the worse case. Most people would pay considerably less than that. Obviously, that involves doctors who accept Medi-

care payment as payment in full. It also expands coverage for skilled nursing home care, for home health care and for hospice care.

Now, you know that Medicare today does not cover prescription drugs and medicines of that kind. I'm very much determined to try to change that so that we provide some coverage for prescriptions because that's a very important part of getting well and it's a very important expense. We're working on that and we hope to have something in the bill to address these costs.

The proposal that is now in the Senate—and I want your thinking about your reactions to this—would increase the basic Medicare premium by $4 a month, in addition to what you now pay. In other words, it would be an increase in the premium of $4 a month or $48 a year in order to get that basic coverage.

This premium will not be sufficient to provide the full Catastrophic Health Care coverage we want to provide. Since the President has laid down the rule that requires people to pay for any improvements, we're trying to devise the best possible way to spread the remaining cost as sparingly as we can to minimize the hardship on people and yet provide this new, valuable protection.

So, your basic Medicare monthly premium would go up by a figure of $4 a month, that would be automatically deducted from your Social Security check as your current Medicare payment is. In addition to that, there would be a second payment, a supplementary payment. But that premium would be on a sliding scale based on your income. About 60 percent of the people in the country wouldn't pay anything in the way of the supplemental premium because their incomes would not be high enough to cause that to kick in.

But people with higher incomes, in the range of $50,000, $60,000 a year, would pay a supplemental premium for this coverage.

If you had as high an income as a couple, of $100,000, there would be a limit of that supplemental payment of a figure of $800.

Now, there's a lot of tinkering going on with how the formula would actually work on this supplemental payment. But I stress that 60 percent of the people on Social Security Medicare wouldn't pay any supplemental premium because it wouldn't start kicking in until people have a fairly high income.

The problem is there is no really good way to find a way to come up with the money. But we're trying through those two means, the basic $4 a month charge that everybody would pay, and then the supplemental part that would be based on your income.

I want to make sure that there's enough understanding here of what we're talking about so we can start from that point. The Catastrophic Health proposals that have been made by the President and now by the Senate and the House deal only with health care for acute illnesses or serious medical problems which are within the present scope of Medicare.

It does not cover things that Medicare today does not cover including things like routine medical exams, dental care or eyeglasses, or prescription drugs, although we're working on covering some part of prescription drugs.

Beyond this, there is another huge problem that's going to be talked about today. There is a growing number of senior citizens

that have a need for long-term care. Long-term care falls in a different category than catastrophic illness as we think about it under Medicare. The cost of nursing home and home health care is very high as you know.

Last year in this country people all across society spent $37 billion on long-term care alone. The average person in a nursing home last year across the country spent $22,000 for 1 year in a nursing home. It doesn't take very many months or very many years in a nursing home to wipe out a person's life savings or the life savings of a whole family.

Now, most nursing home care, or home care is not covered by Medicare. If you run out of money, are reduced to poverty, go on welfare and qualify for Medicaid, then Medicaid will help you pay those bills. But of course you have to exhaust yourself financially before that happens.

That's very, very difficult for people, particularly when a husband or a wife is in a nursing home and the spouse is trying to live on the remaining money. The assets of the couple have to be drawn way down virtually to zero before Medicaid starts picking up those nursing home costs.

So, when Medicaid does finally pay for the cost of a nursing home for the person, who needs that care, the other partner in the marriage who is still outside of the nursing home is forced into poverty.

This is a terrible problem. At present we don't have a way to pay for this $37 billion a year in long-term care costs that are being experienced by the American people. Nursing homes are just a part of the problem, because we know that there are lots of people that are being kept in homes with family members.

This is going on because families can't afford to have somebody in the nursing home setting, even though they might actually be better off and get better care.

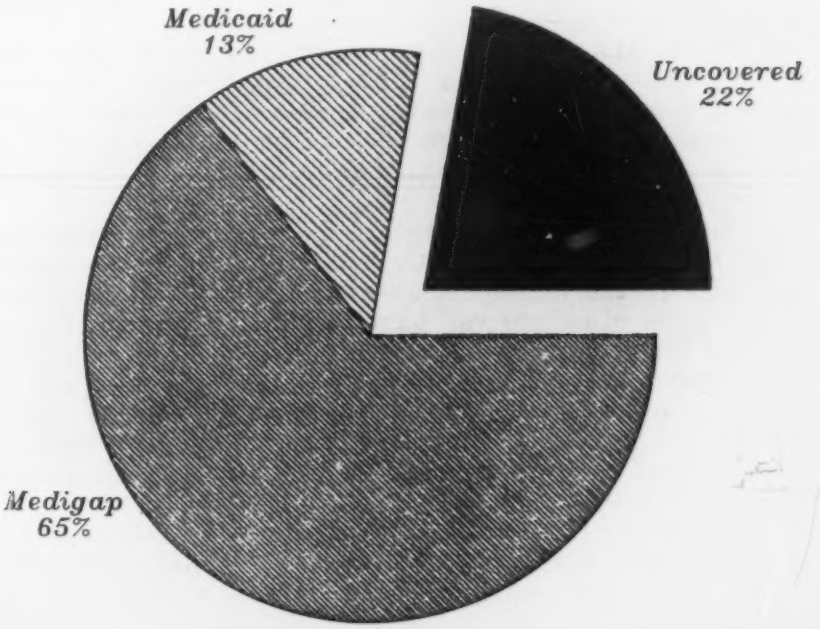
So, as part of this legislation we are setting in motion a study to analyze how we might go about, as a nation, facing up to the cost of long-term care for senior citizens because that too is part of the problem of catastrophic illness.

It can wipe out your money the same way as somebody who gets a cancer or somebody who has some other serious illness going into a hospital for a long period of time. Some way or another, we've got to find an answer to this problem.

I just want to quickly refer to these charts. Then I'm going to call on our first witnesses. I want to show you these two charts because they illustrate the problem and will give you a frame of reference.

This circle shows how expenses for acute health that are not paid by Medicare, are currently covered. These are the costs that this legislation tries to deal with.

CATASTROPHIC HEALTH CARE COVERAGE FOR SENIOR CITIZENS



At the present time 13 percent of those costs are being paid by Medicaid for people who have actually exhausted their savings. But of course you have to exhaust yourself financially in order to have your catastrophic bills picked up under that welfare program.

Sixty-five percent of these Catastrophic Health Care costs today are being covered by these various Medigap plans. When I asked how many people here have those private plans to supplement your Medicare, a very large number of hands went up in the room. So this portion of all the total costs, which is a very substantial portion, two-thirds, is now being picked up by those Medigap plans.

But as you know from having those Medigap plans, those plans, can be very expensive. They range in price from about $300 a year to as much as, $900 a year.

Because it's hard to keep track of it all, some seniors may actually be spending more than they need to because they're buying more protection than it's really wise for them to buy. But people get frightened. And understandably so because it's frightening to think that one illness could take away all your remaining money.

Finally, 22 percent of our seniors are totally uncovered beyond Medicare. Those of you who have Medicare coverage but may not have the money or may never have taken out these private Medigap plans, would be in this category.

And of course you're at risk every single day. If you have a major illness, once you've exhausted the limited benefits under Medicare, and you don't have a separate private plan then the rest of it has to come out of your own pocket. You could have to draw down the rest of what you have until eventually most of your

money is gone. Then you would shift over into the category of people who are eligible for Medicaid because you've exhausted your assets.

The bill we are considering would also take care of this group.

Depending on the size of your income, you might have a supplemental premium, but if you have catastrophic health care needs that arise, they would be met for you. So, this group would be covered.

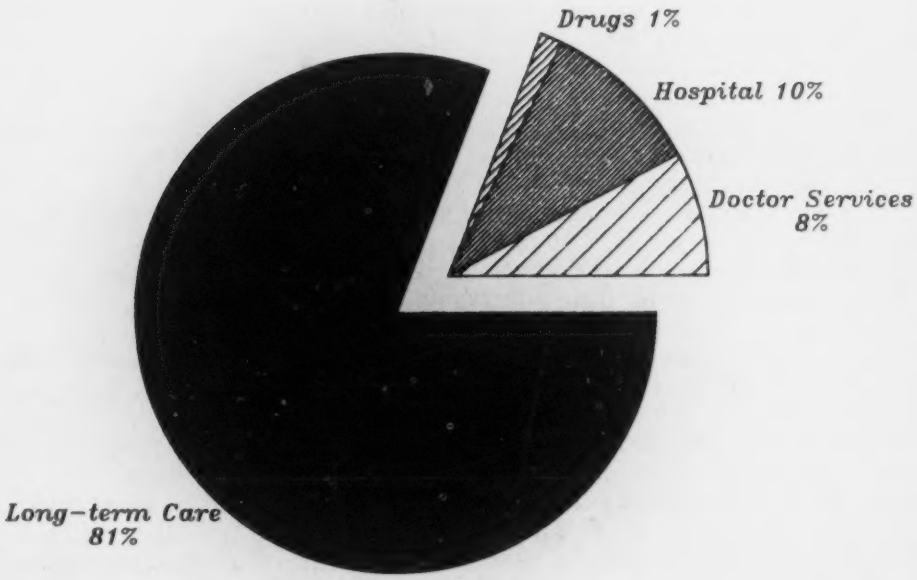
Those of you that do have private Medigap plans would find, in many cases, that you will not need these Medigap plans, because most of them are written to provide the coverage that would now be provided by Medicare if these new proposals are enacted. So, you wouldn't want to go out and buy a private plan to duplicate what you would be getting from Medicare.

Now, you still might want a private plan for something that Medicare still wouldn't cover, whether it's dental care, or eyeglasses or something else.

So, you might want to consider still having a scaled down private plan in addition. But generally speaking, people who now have bought this private coverage would be getting most of that coverage for Medicare and at a lower figure for most beneficiaries.

Now, I want to show you one other chart, then we're going to go to our witnesses. Everything you see—this whole pie represents all of the catastrophic health care cost currently being incurred by this country's elderly citizens.

CATASTROPHIC OUT-OF-POCKET EXPENSES OF THE ELDERLY



This great big area here is the cost of long-term care that I spoke about which now is not covered under Medicare and would not be covered under the new changes.

In other words, that's a part of the problem that we don't have a solution for yet, and I'm not saying that because I'm happy about it, because I'm not happy about it, but I don't want people to be confused. Many people, when they go on Medicare, assume that that means that everything is going to be covered—that the nursing home care, if they need it in the future, is going to be covered.

In fact, as you know, it is not covered unless you exhaust all of your assets and you go on public assistance. Then it would be paid for by Medicaid. But short of that, you have got to pay for it out of your own pocket.

And today, the total cost of long-term health care represents 81 percent of the catastrophic costs seniors pay out of their own pockets. The rest is the amount of money that's being spent on acute catastrophic illnesses that will generally be covered in the new legislation.

Of this catastrophic part, 10 percent of it goes for hospital bills, 8 percent goes for doctor services, and 1 percent of it goes for drugs.

I show you this chart so that everybody is clear on the fact that even if we solved this problem, which we think we can largely solve with this new proposal, takes care of this wedge of the total of expenses facing people. We still have an unmet problem here in this country with long-term care that we're going to have to find a way to somehow come to grips with.

And I say that because more and more people are living longer, with advances in medicine and in care. The cost of living is high and people in many instances will live beyond their financial resources. So, we have to figure out what we're going to do about this problem as well.

Now, we're going to go to two sets of witnesses. I can feel the air-conditioning is on. Is everybody comfortable in the room? Is it too warm, too cold?

The AUDIENCE. It's cold.

Senator RIEGLE. I'm too cold too. Maybe we can get the air conditioning turned off for a while.

The AUDIENCE. No.

Senator RIEGLE. All right, this side of the room isn't too cold. I know when I'm licked. Let me get out of the climate business. I'm going to have enough to do with health care here. I'll let the people who own the building figure out how to turn up and down the temperature.

Let me introduce our first three witnesses and tell you who they are. And if I may, could I just ask you, because the room is so big, if the three of you just stand and face the audience. That way, as I introduce you, people can see who you are. When I say your name, maybe you could just raise your hand so they know who you are, and then I'll have you turn back around, sit down then we'll begin.

Let me now ask you if you would stand up and face the audience. These three witnesses have been very, very gracious about agreeing to come and to speak today and I want to introduce them to you.

First, is Mr. Charles Diekman. Charles has been caring for his wife who has Alzheimer's disease. Mrs. Diekman has been ill for

about the past 5 years. He is going to be talking to us about the problems that they have experienced and about the need for what we call in-home custodial services.

Charles is dealing with his problem. You know, we all have to just sort of lay the facts out here. He's 70 years old and that's not an easy problem to deal with at any point in your life, but that's where he is and that's what he and his wife are dealing with. So, he'll speak to that.

Next to Charles is Betty Chatfield. Betty recently lost her father to a chronic brain syndrome. She's here today to address the needs of many families who care for the aged, their parents, and to tell about how you meet these needs emotionally and how they really drain a family financially and emotionally.

I'm particularly grateful for her to be here and willing to talk and testify so soon after the loss of her father. So, that's a very special thing she is doing for us and we're deeply appreciative.

Finally, Danice Chisolm is an executive director of Care Givers, Inc., which serves the needs of the aged and disabled of Metropolitan Detroit. This group provides a respite services to those who provide care of the long-termed ill person. Care Givers is funded by grants from the Area Agency on Aging and the United Community Fund and is a non-profit organization.

Now, are we going to have the witnesses come to the center microphone?

Mr. KRAWITZ. Right.

Senator RIEGLE. I think because we have so many people in the room and I'm learning myself as I am talking, you have to talk right into the microphone in order to get the sound all the way through the room. So, I'm going to ask our witnesses to be conscious of that and I'm going to start with you Charles, if you will, come on up to the microphone in the center. We'll make sure it's working.

Do you feel comfortable from testifying there? Why don't you come up to that spot and take a minute to get that microphone adjusted and speak right into and if I sense that your voice isn't getting out into the room——

STATEMENT OF CHARLES DIEKMAN, DETROIT, MI

Mr. DIEKMAN. OK. Senator Riegle, I'm here today to testify about the need for health insurance to help people in my situation. As you have already stated I am 70 years old, my wife Ruth is 69.

With hindsight, I believe that she has been ill since 1980. The symptoms were first noticed by our children when Ruth and I had our 40th anniversary celebration and Ruth was entirely confused. She did not know where she was or what was going on.

Senator RIEGLE. Can you hear in the back of the room?

The AUDENCE. Yes.

Mr. DIEKMAN. After the celebration sometime later, I took her to a neurologist who made all the checks and sent us to Mount Carmel Merch Hospital where Ruth was tested. The tests were not definite.

Sometime later, I was able to get her into the University of Michigan Hospital where Alzheimer's disease was confirmed in

1984. At that time, I found an organization called Alzheimer's Disease and Related Disorders Association who had support groups in the area which I've joined and have helped me over this time.

Since that time, there has been a constant deterioration of her health. She can no longer talk, she can't dress herself anymore, nor can she bathe herself. Often, she's unable to feed herself.

She needs help, and worst of all she becomes angry. She's angry because she's frustrated by what she cannot do. Right now, I'm able to take her to a day care center 3 days a week. The center is sponsored by the Catholic Social Services of Oakland County. However, when Ruth gets to the point where she needs diapers, daycare will not be able to take care of her any longer.

I provide care for her 24 hours a day, 7 days a week. I worked hard all my life. I saved my money and prepared for my retirement. My monthly income is high, almost $1,900. I know I am fortunate to have this income, but this income won't cover what it will cost if Ruth needs personal home care or if I am no longer able to care for her. It won't cover the cost for paying for someone to come to our home to care for her. No insurance plan will pay for this type or care either.

We have enough savings to provide for about 1½ years of nursing home care and then she would be eligible for Medicaid after our savings are spent. I'm advised of the $1,900 monthly income I now have, I'll be forced to live on, under $400 a month according to Medicare rules.

I have also been advised that I should divorce my wife so that I could protect my future years. This is something I can't think about after 45 years of marriage, but something I may be forced to do.

I'm asking you Senator Riegle to help me and others like me who need a health insurance plan to pay for long-term nursing care. I ask for your help, sir.

Senator RIEGLE. Mr. Diekman, that's a very powerful story, and I want to thank you, and I know everybody in the room thanks you for sharing that.

It's hard to talk about, it's hard to think about. But what we have to recognize is that any and all of us can be in this situation someday, and we can be either in his situation or his wife's situation because this is life and this is how things happen. So, we have got to have a way in which to respond and deal with this.

Now, I'm going to ask you a few questions, but I think what I'm going to do is let the other two witnesses also speak and then I'll have you take your seat and then I'll call on you and then we'll work from this microphone at this table and then I can ask questions of each of the three of you. But I want to thank you very much for your testimony.

Betty, can we ask you to come up now. Let me also say that if you can get as close to the microphone as possible that will help. You may need to pull it down just a little bit. We really appreciate your coming.

STATEMENT OF BETTY CHATFIELD, UTICA, MI

Mrs. CHATFIELD. Thank you, Senator, good morning. My name is Betty Chatfield and my husband James and I along with our two children——

Senator RIEGLE. Can you hear? They can't hear you. You have to get a little closer. You have to get right up to the microphone and talk a little louder if you can. If you could about an inch away, that will actually help. Another way to do it is you can take the microphone out and hold it close to your face like this.

Mrs. CHATFIELD. I think I can make it.

Senator RIEGLE. OK.

Mrs. CHATFIELD. My name is Betty Chatfield. My husband James and I along with our two children have a home at 12211 Twenty-five Mile Road, Utica, Michigan. However, for the last 18 months, we've resided with my parents Grela, who is now deceased, and my mother Marcela Hammalback in their home.

My father had Organic Brain Syndrome which is a related syndrome to Alzheimer's disease. The symptoms are very similar; however, the underlying causes are very different. Organic Brain Syndrome is the accumulative result of numerous mini strokes ultimately resulting in complete mental and physical dependence.

Approximately 8 years ago my father's condition became apparent. As the symptoms began to manifest themselves, we as a family, became alarmed. Only after seeking the opinion of several neurologists, cardiologists, psychiatrists and geriatric specialist were we told that to no avail Organic Brain Syndrome would be a gradual step down process.

As a result of my mother's deteriorating health, in-home care for dad became necessary in 1981. We tried to hold services to a minimum due to cost. My father's monthly income totalled $702, my mother's income $205, totalling $907 per month. These figures were based upon my father's earnings prior to his retirement in 1969.

As mother's health continued to deteriorate, more and more in-home care was required. Their savings of $8,000 was depleted as of 1985 to $1,500. As you can clearly see from the figures given, in-home care services were kept to a minimum and supplemented by myself and my family in an effort to reduce the cost to my parents.

Our family of four has been living on Social Security disability since 1978 when my husband was deemed permanently and totally disabled due to the residual effects of chemotherapy. Consequently, we were not able to assist financially. We could only offer them the physical and emotional support and assistance that we could provide.

All efforts were made to keep my father home for as long as we were able to provide him the care and management he required. We gave consideration to placing him in a basic care nursing home; however, my mother's non-prescription medical needs alone totaled $237 a month of which some of these to give an example were diabetic supplies, special dietary needs, contact lens supplies, et cetera.

Financially, she would have been unable to live and meet her immediate medical needs on the combined income of Social Security supplemental income and social services. This unfortunate conclu-

sion was not only mine, but that of numerous social workers who attempted to assist us with our dilemma.

We were told by father's attending physician in March of this year that Medicare would no longer pay his services or hospital care for dad's repeated admissions given the diagnosis of respiratory distress or complications of T.I.A. or "mini-stroke syndrome".

Hospice care is not an option to patients of Alzheimer's disease or related disorders. Having knowledge of this combined with the other facts given, we were left to conclude that dad's care and/or lack of medical attention would ultimately result in his demise at home.

It was only after my 13-year-old son attempted suicide by hanging in February of this year, did I, acting as my father's conservator and guardian, place him in a Medicaid participating facility that could and did provide both basic and skilled care.

This decision was based upon our son's critical needs for all the time and attention that we provided to dad's care would have to be directed toward our son's recovery, without regard to the financial hardship it would and did place upon my mother. All of dad's Social Security and pension supplemented by the Department of Social Services was used to pay this $1,865 a month bill with the nursing home; leaving my mother $337 a month to sustain herself.

My father entered his eternal life May 14, and only the physical, emotional, and financial losses remain.

I would like to conclude by thanking all of you for your interest you have expressed and sincerely hope that your efforts to help families touched by this and similar exhaustive diseases will be blessed with success.

Senator RIEGLE. I know we have a lot of other stories in the room just like this that other people could tell if they were coming to speak. I want to especially thank you, the two of you, because of the pain and difficulty of the situations that you're involved in, for having the courage and the strength to come today and to tell these personal stories and to share them with everybody else. I know that's not easy, but it's a great service that you perform to your country and to everybody else and we're deeply appreciative of that.

I'm going to ask now Danice if you would come and give your statement.

STATEMENT OF M. DANICE CHISOLM, EXECUTIVE DIRECTOR, ACSW

Ms. CHISOLM. Senator, the reality of the long-term care issue is that most people are being cared for at home as these two people have discussed. For a variety of reasons, some because of the lack of insurances, as Mrs. Chatfield described, but also because of commitments, wanting someone to be able to remain at home. It's the place we all would like to be under any kind of crisis or difficult situation.

We choose to be at home with people we love and we have a commitment to one another to take care of one another. It's part of our human condition. So, consequently that is where most of the long-term care needs are today.

But in some communities such as your 22 percent shows, it is insurance. We're fortunate in our area in that many of the people here do have good medigap insurance because of our UAW insurance programs. And I'm very concerned about those younger people and those I mean are the 50-year-olds and under when we look at what the employment conditions are now for the UAW employee and others. They are not facing that kind of retirement future and will not have the kind of insurance plans I'm afraid that hopefully people today have.

So, this kind of coverage is very important for the future retiree, but of course in other parts of the country, employers do not provide for catastrophic coverage for people. We're very fortunate here to have that.

When someone takes care of someone at home as you have described and as our two prior speakers have discussed, it isn't simple. There are out-of-pocket expenses. There are special skills that they need to have. There's a total loss of any kind of personal life. There's an isolation from the familiar world which often causes deterioration in their own family life, deterioration of the family caretaker's health and well being also, and these are heavy prices to pay to keep someone at home.

So, let me focus just on five major problems that I've seen happening like this. One are out-of-pocket expenses that people have. Adult diapers, feeding tubes, the supplies to them with, absorbent pads, diabetic supplies; all of these non-durable medical goods. They don't require a prescription, but they cost a lot of money. And they're with you for the whole period of time the person is home and you need more and more of them as their health deteriorates.

You have to have a sizeable income for it to have any income tax impact. And that's really a reality for most retired individuals. So, there needs to be some kind of financial support from insurances from these out-of-pocket non-durable medical expenses.

And you've spoken most eloquently toward the problem of the Medicaid personal property levels. They are just absolutely too low. There are $1,700 and $2,500 for a couple. While the person is struggling to take care of another individual.

Senator RIEGLE. Let me just stop you there. Does everybody understand what she just said because it's very important that we do that. Some of you will know and some of you will not, but I'm going to just emphasize again and have you cite the figures.

She's indicating how much you have to exhaust your financial savings when you have major medical bills before you finally get to the point where Medicaid will kick in. In other words, when you finally reach the point where you qualify for Medicaid as a welfare benefit you have to draw your personal assets down to an individual, it's a figure of——

Ms. CHISOLM. $1,700.

Senator RIEGLE. $1,700. In other words, you have to exhaust yourself financially until you have only that much that left or a couple——

Ms. CHISOLM. $2,500.

Senator RIEGLE. $2,500 for a couple. So, you have this terrible dilemma where if somebody is going to finally qualify for the welfare health coverage payment, you literally have to put yourself in a

poverty condition to do it. Then of course, the consequences are what happens to that half of the marriage at that point when their, all of their wear-with-all is gone.

In other words, you in essence, you try to solve one problem but at the same time you create another terrible problem in the process. But in any event—I just want to make sure that everybody in the room understood the point that you're making.

Ms. CHISOLM. I would recommend that $5 and $10 thousand would not be an unreasonable amount. They still leave a person with something to deal with for emergencies and I don't believe that we would see sizeable increases under people going under Medicaid with that level.

As you've heard people need someone coming into the home to help them and we ought to be providing some kind of consumer protection for them whether they got to an organization for that care or go to private providers. So, we should have some standards for the kind of home care that can be provided.

Prior to the revision of the Social Security Act in the mid-1970's no Federal dollars could be placed in an in-home program where the homemaker, home health aides were not trained according to the standards of the National Home Caring Council. And when Title XX came in, that clause was eliminated.

So, even in our Federal dollar programs we don't require that those standards be adhered to. There are only four programs in Michigan, out of 400 to 500 agencies operating that are accredited by the National Home Caring Council.

So, while a person is in this very vulnerable situation, obviously having to reach out and have someone come into their home to help them, they don't have any idea who they're going to be, how they can rely on them.

We're not doing anything on a national basis that we've set up some standards and we expect the people that are coming into your home to at least have some basic minimum knowledge to be reliable in some basic ways.

Those things could be done in a variety of ways. With initiatives toward training, there could be some kind of program training incentives. There are a variety of things that could be done that wouldn't be all that costly to do.

Both of our speakers earlier have discussed overwhelming demands that were placed on them in taking care of someone, and they need respite, they need relief from that. We are forging ahead some with the respite care programs, but they are all in medical models.

We're looking at rehabilitative day care in our insurance programs and I'm convinced that no more than 10 percent of our need is for medical programs. They're expensive and they're beyond what's needed.

We need social model programs. That's what will meet the needs of both of our prior speakers. That's the way to be cost effective about it and it can be done that way. So, we have to be careful when we design them not to just pick up what has been the pattern in the critical care, in-home care program, but to look at alternate models which actually meet the long-term care needs, not crit-

ical care needs. They will cost less, they will be designed different, but they will be the ones that are more appropriate for us.

And finally, with long-term care, we know that we don't have any insurance that provides for the long-term support, the personal care, the home-maker services or the respite care. And there isn't a person who's been hit with those things who doesn't realize that lack.

It's being done in Europe, Senator, we know that. They have programs all over Europe that are social models and home-base programs that work very effectively that have good structure and are cost effectively run and certainly we can do it for ourselves, I would think.

Senator RIEGLE. You know, the comment was made earlier about we've now just heard these three witnesses and our Federal Government each year, our budget at the present time is roughly $1 trillion is what we're spending. It's a very, very high figure. A very large part of that goes for National Defense which was mentioned; our agricultural programs and various other things.

And one of the questions that we have to face as a nation is what is the most important thing to us or what are the most important things to us. Obviously, we need education is important because we've got to develop our capacities if we're going to be able to function well in the kind of world that we now live in.

We know that health care needs have to be met. To let somebody suffer, to let a family suffer because we are now putting ourselves in a position to meet these medical needs or health care needs seems to me should be right at the top of our list, and we have to make some decisions as a nation.

This is a budge committee hearing that we're having here today and I serve on the Budget Committee, and there isn't enough money to go around and so we have to think through as a society together what we're going to say yes to and what we're going to say no to because we can't say yes to everything because we don't have enough money to do everything that we could imagine doing. One of the questions that we have to decide as a country is how important these health care needs are. Not just for ourselves, but for everybody.

If we're going to be a nation that sticks together, we have to care about each other. And today we might hear the story of one family that's in terrible trouble. Maybe we're not in trouble in our family, but tomorrow we could be in trouble. And if God is fortunate and smiles on us so that we never have the problem ourselves, then that's our good fortune, but it seems to me we ought to be willing to do something to help the person next door, or down the street, or across town who has a problem. [Audience applauds.]

I think we have to be a society that cares about each other in terms of these kinds of devastating problems. No matter what church we belong to, or synagogue or what faith or even if we don't belong to a church, it seems to me that what happens to our neighbors and others in our community and what could happen to us is something that we have to pay attention to.

And so, one of the tests that I have to meet because I have to vote each day in the Senate and I think you have to meet along

with me, we have to meet together, is in deciding what is the most important thing for us to concentrate on.

Have the health needs of our country and the costs of these kinds of care and services and medical attention gotten to the point where we really need to change the focus and emphasis of our Government so that we do less of something else so we can do more in this area?

And I'm going to give you one to think about. I don't want to get started into a political debate here today. That's not our purpose and if we did, we could be here for several days. But I want to just tell you about one item that's coming down the track and give you its price tag because you're reading about it and hearing about it.

It's in the defense program. It's called SDI, the Star Wars program. There's a big controversy about it because some people say it will work, some people say it won't work. So, you've got a lot of division on that issue by itself.

One thing that nobody is arguing about is the price tag because it's very expensive and it's been estimated that to build a Star Wars program in addition to all of the military arsenal and inventory that we have today would cost a trillion dollars. A trillion dollars. A trillion dollars is a lot of money.

I'll tell you how much it is. I'll tell you how much it is because you're going to hear trillion dollars talked about more and more. You know a million dollars is a lot of money and there's a billion dollars and now we're talking about a trillion dollars.

If you won the lottery in Michigan and you won a million dollars and they paid you with brand new $1,000 bills, crisp, unwrinkled, brand new $1,000 bills. This is a stack 8 inches high. That's $1 billion.

If you had that stack of brand new $1,000 bills 8 inches high at $1 million, you could live pretty well for a long time; $1 billion is a stack of those $1,000 bills higher than the Washington Monument. Now, that's the difference between a billion and a million, but a trillion is a thousand stacks of those brand new $1,000 bills higher than the Washington Monument. Now, that's a lot of money. That's a lot of money.

And so, before we just go down a road that says well, let's spend it, we better think about the other needs that we have in our daily lives, up and down our streets, because you know where that money comes from? It comes right out of your pocket. It comes right out of the sweat of the work in your own life and people in our State know what hard work is all about.

Because when you work in a manufacturing area the country and especially if you look at our history over the last several years in this century, leading up to people who are now retirees and of senior age. People that earned a living in Michigan really paid for it, a lot of times with their health. There are those that have survived that are in decent health at the retirement age and are very fortunate because there are a lot that aren't. A lot who have gone out under Social Security because of their health that has been broken just because of the kind of work and how hard a lot of the work has been done in this State.

So, meeting these human needs is a very serious matter. And we have to decide as a society what counts the most, and where we

think the emphasis should go. The country is going to need to hear from you. They hear from me when I vote and I hear from you, but we have got to make sure that all of the elected leaders, the President, the Vice President, the Congress as a whole, the Congressman that represents you now, that everybody has a chance to get a sense for how you feel and what you think is most important.

And I have the feeling today that this capacity crowd is a statement, not just by those who speak, but by those who come and speak by coming, speak by their presence. That you want to see something done in terms of facing up to these health care needs and want to see a civilized and humane society where people are able to live decently throughout their whole lives including when they reach senior citizen age and their health may be breaking down. That they and their family have a way to live without being driven into bankruptcy and into poverty and onto welfare. I think that's what this crowd is saying.

I'm going to ask a few of our witnesses questions here at this point for the record. So, let me start Betty with you, if I may, and I'm going to ask Joan to offer you the microphone. You can just speak right into that when you answer.

Now, you told us this very sad and touching story about your father. I'm interested, how is your mother's health? What is she facing at this point? Are you looking at problems with her health too now, what may be going in that area?

Mrs. CHATFIELD. Yes, my mother has a very serious heart condition. Last August she underwent a quadruple bypass with little or no success. She's very serious. We're actually doing everything to place her in a skilled care facility.

Senator RIEGLE. So, it sounds to me that after having gone through this ordeal with your father's health over a length of time, you're now experiencing very serious problems with your mother's health as well. So, you're going from one problem to the other.

Now, you mentioned when you learned in March, you did learn in March that Medicare would no longer pay for hospital services for your dad. Could you tell us why that was?

Mrs. CHATFIELD. I understood from his doctor that the same diagnosis was the problem. That the diagnosis of TIA, Organic Brain Syndrome and its complications that would arise after these mini-strokes of respiratory distress was the continual admissions given the same diagnosis.

Senator RIEGLE. Did he exceed the number of days that he would presently have in the hospital of Medicare?

Mrs. CHATFIELD. No, he did not.

Senator RIEGLE. Did he go over that limit?

Mrs. CHATFIELD. No, he did not.

Senator RIEGLE. A lot of times some do. Your father didn't, but many do. They go over the limit and of course then there's just a huge expense that is incurred and that's one of the things that we hope to take care of.

Let me ask you if you could pass the microphone over to Mr. Diekman. Mr. Diekman, you're providing this care for your wife literally 24 hours a day. How do you manage? How do you get rest or are you just on call all hours of the day or night, what happens?

Mr. DIEKMAN. Well, I usually about 8 o'clock in the evening, put her to bed. And then when I go to bed after the news at 11:30, I attempt to sleep with one leg against her body or my arm and leg against her body. So then when she moves constantly, she'll awake me. Maybe even get 30 minutes sleep at night you're lucky each hour.

Senator RIEGLE. I see. So, you may get 30 minutes an hour of sleep at night and then you're awake for 30 minutes of that hour. So, you're just up and down all night long?

Mr. DIEKMAN. That's right. She's totally restless all night long.

Senator RIEGLE. What effect is this having on your health; can you tell? You're obviously doing everything you can to stay strong for her, but how are you managing to keep with so little sleep at night and your sleep interrupted this way and so forth?

Mr. DIEKMAN. As I told you before, I have her in a day care center out there 3 days a week. One day is taking care of the yard outside, 1 day is shopping, 1 day is cleaning house. And I attempt to get an hour or two of sleep at that time, just by laying down and going to sleep. And I don't have any problem with that.

Sometimes during the day, if she's home on Friday, Saturday, Sunday and Monday after breakfast in the morning and after she's ready to do what she wants to do and whatever we can do, she'll sit down in the chair at home and go sound asleep. At that time, I try to sneak a nap too because that's the only way out of it. Whenever she dozes off, I attempt to doze off too.

Senator RIEGLE. Do you have any other insurance coverage, private insurance coverage for health coverage?

Mr. DIEKMAN. Yes, PMG from the gas company in Detroit.

Senator RIEGLE. And that relates to your previous work?

Mr. DIEKMAN. Yes, sir.

Senator RIEGLE. I see. But do you have any kind of like medigap or anything of that sort that you also pay for on the side or not?

Mr. DIEKMAN. No, sir.

Senator RIEGLE. Let me just ask you how you feel about the idea of the proposal that's before the Senate now to try to take and meet some of these catastrophic health care costs. If you had to pay a slightly higher premium each month about $4 each month in order to get the broader coverage, does that sound like something we ought to do?

Mr. DIEKMAN. Sir, the nursing homes that I've checked into run about $2,000 a month.

Senator RIEGLE. Right.

Mr. DIEKMAN. Plus the cost of blue pads. You're not allowed to bring in your own prescriptions, you have to go through their druggist and the bills are phenomenal. At $4 a month or even $10 a month I would be more than willing to pay whatever there is to be paid to get some kind of insurance to help out through this crisis.

Senator RIEGLE. Let me ask you, I'm just going to ask for a show of hands around the room because I want everybody to have a chance to participate. So, let me put a couple or questions just to everybody in the room, including our panelist here.

And that is how many of you feel that it is really urgent in our country that we take and find a way however we end up, you know, crafting this legislation to find a way to cover these gaps in

Medicare and to get it done this year? How many feel that this is really an urgent matter?

[Audience complies.]

Senator RIEGLE. All right, now let me ask you this, how many of you feel that we can do this and that you're prepared to live within the notion that the President has laid down that says at least for now, any improvement in this insurance coverage we're going to have to pay for? We're going to have to have it in terms of an offset in our monthly benefit.

How many of you support the idea of that kind of a system if that's the best we can do at this point?

[Audience complies.]

Senator RIEGLE. Most of you would support that as well, I'm sure. How many of you would descent from that? How many of you would say that we ought to find just general government financing or something else to do it? And I see a scattering of hands.

Let me ask one other question of the audience right now and that's this: bear in mind Medicare today does not cover long-term nursing care unless you exhaust all of your assets, come down to these low limits that we were talking about and then Medicaid will pay for that long-term nursing care. And the theory is behind the way the law is today is that people have to somehow through their lifetime earn enough, save enough, whatever to pay for those long-term nursing care costs out of their pocket.

Now, we know a very large number of people in our society can't earn and save that much. No matter how frugal you are, you just can't do it. Especially when, on the average, nursing homes cost $22,000 a year. Most people just don't have that kind of income or those kind of assets to draw down for very long.

So, how many of you would feel that we're now to a point because of the aging of our population and the number of people involved that we have to take on this red area, this long-term nursing home care issue and find some way even if the Government has to pay part of it? Even if maybe it means that the Government doesn't do Star Wars or doesn't do something else so that it gets the money.

How many of you feel that the time has come to go to work to find an answer to get the cost of long-term nursing care down to a point where they're manageable for us as a society so that people are not driven to the poor house in order to get the care they need? Let me just see a show of hands on that.

[Audience complies.]

Senator RIEGLE. I thank you for that because it's important that we understand what it is that we want to try to accomplish. It's very important for me to get guidance from you on issues of this kind so that we can decide together what it is that we need to set as our goal, what it is that we need to try to find an answer to and also the question of how serious this problem is.

If it's so serious, then it means we have to give it a top priority rather than to treat it as something that we can get to 5 years or 10 years down the road.

And the sense that I'm getting from you today is that you think this is a top priority issue and something that needs to be dealt with now——

The AUDIENCE. [Applause.]

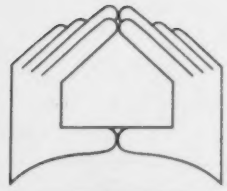
Senator RIEGLE. That that's what you expect us to do. Let me tell you what I'm going to do. We're going to go to the next panel, but I'm going to take about a 5 minute break here so that anybody that needs to get a drink of water or go to the restroom or stretch or what have you has a chance to do so. Let's plan to be back in our seats by 5, 6, 7 minutes from now so we can pick up with our next panel.

[Whereupon a recess was taken.]

Senator RIEGLE. Let me invite all of you to come back in and find a seat. As we're coming back in and getting seated, I'm going to put a couple of questions to the audience that have been suggested. I'm wondering how many people here today are presently caring for someone in their own home who needs home health care. How many people here today have someone in your home that you're caring for in that capacity? Let me see the hands. I see about two dozen hands going up. All right, thank you.

Let me ask another question, this was suggested to me. How many of you are experiencing a problem in your family circle with anyone who has Alzheimer's disease? Again, about two dozen. Thank you.

[The prepared statement of Ms. Chisolm follows:]



CareGivers

Administration/
Wayne County Service
51 W. Warren Ave., Suite 208
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313/833-0635

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313/334-5100

Mrs. Powell L. Cozart
President

Ms. M. Danice Chisholm, ACSW
Executive Director

June 1, 1987

Honorable Donald W. Riegle
30800 Van Dyke
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Warren, Michigan 48093

My dear Senator:

Thank you for your interest in the impact of catastrophic and long term illness on families in our community. I am privileged to present to you several significant issues which we regularly find in the in-home care field for your study and consideration.

Let's look at some demographic trends:

-Our median age is increasing;

-The over 80 age group is the fastest growing;

-Our technological advances are improving our ability to prolong the average life span and to increase the degree of quality of life for some of us as advancy years come on.

These facts describe a growing population of older persons, who, quite naturally, are not always able to maintain themselves at home without a helping hand.

And, the reality is, that most people with long term care needs <u>are</u> remaining at home. And in some communities where poor catastrophic health insurance coverage is common - these people are also remaining at home.

Why?

Sometimes, there is no insurance to cover the needed care and I am very concerned about the future of the younger Michigan resident because it is unlikely that many of them will have the caring, retirement plans which many UAW/Big three retirees have now.

Othertimes, especially when a nursing home placement is the alternative, the family and the dependent person want that person to remain at home.

But it's not that simple. There are out of pocket expenses, specialized skills needed, loss of a personal life and an isolation from the familiar world which often results in deterioration of the family caretaker's health and well being also. There are very heavy prices to pay to keep someone at home.

Let me focus on five major problems:

*Out of Pocket Expenses

Adult diapers, feeding tube supplies and liquids, absorbent pads, non durable medical goods. They don't require a Rx, but they cost a lot of money. You have to have a sizable income for the income tax deduction to be helpful. Most older persons just pay this out of their pocket with no hope of financial support from income tax or insurance.

*Medicaid Personal Property Levels

There are services available through Medicaid, however, the personal property levels are so low that the surviving spouse is left near destitute and how then does he or she make it? Add to that the worry of having no nest egg to fall back on in an emergency while you're coping with an impossible situation! Increasing the levels to even $5,000 for a single person and $10,000 for a couple would not likely significantly increase the number of people using Medicaid, but would be more realistic and humane.

*National Standards for Home Care

Prior to the revision of the Social Security Act in the mid 1970's (with Title XX defining social services) no Federal dollars could be

*National Standards for Home Care (Cont'd)

placed in an in-home program where the homemaker-home health aides were not trained according to the Standards of the National HomeCaring Council. The Standard Setting organization establishes criteria for programs and training. In Michigan only 4 of over 400 In-home Service are accredited. **CareGivers**, of course, is one. There must be protection for these people who are vulnerable. The government can structure guidelines which would give the consumer - of either an agency service or private care - some assurance of skill on part of Aides, through a range of training program incentives and initiatives.

*Social Model Respite Care

Caring for someone 24 hours/day, seven days/week is exhausting, debilitating and demoralizing. Family caretakers need a helping hand - to get away for a few hours each week and occasional weekend. They don't usually need a medically supervised program, through. Rehabilitative day care, and other medical models are important - but expensive - and, I believe - 90% of all Respite Care needed can follow a Social Model/ cost effectively.

*Long Term Care In The Home

We don't have insurance for the Long Term support of personal care, homemaker and respite care in the home. There isn't a person whose been hit with the need who doesn't realize the lack. Careful structure of the programs can assure that we don't turn it into a high cost/ hour program.

Senator, I'm available to review these and other issues in-depth with you and your staff at any time. Thank you for your attention today.

Yours truly,

M. Danice Chisholm

M. Danice Chisholm

Senator RIEGLE. All right, we're going to proceed and I know that there will be people coming in and out because some need to be leaving and so forth. So, we'll just continue on.

After we finish with the second panel, we're going to go to statements from those of you in the audience who wish to make a statement. I have several people who have already indicated a desire. So, I've got some names on sheets of people who've already said that they want to be called on. We're going to call on them in the order that we've got the sheets and anybody else that wants to.

I made a pledge in the beginning, and we're going to keep it, and that is we're not going to shut things down today until everybody that asked to speak has a chance to speak.

So, let me now introduce our second panel. Our second panel is made up of representatives of the Health Care profession and they are here to talk about the problems of catastrophic illnesses and health needs from the perspectives of their vantage point for actually trying to provide health care. And they are these three individuals and let me ask them to, if they will, stand and face the audience as I introduce them. Then as you're introduced, if you'll just raise your hand so we know who you are.

First, Catherine Price is the executive vice president of Mercy Services for the Aging which is a subsidiary corporation of Mercy Health Services. Mercy Services for the Aging was formed to meet the need for alternative health care and housing for the elderly because these needs were not being met by current acute care hospital services.

Then, Mr. John Keeler is the Geriatric Development Program Coordinator for the Henry Ford Hospital and is here today as a representative of the Southeast Michigan Hospital Council. And then finally, in the center Roberta Humphries is the president-elect of the Michigan Home Health Care Assembly which is an organization comprised of 120 home health care providers throughout the state. Miss Humphries also is an administrator of the St. Clare Home Health Care.

We're going to start first by having Catherine Price, if you would, come on up to the microphone and again, I'll urge you to speak right into the mike like the other so everyone in the room can hear you. The closer you are probably the stronger your voice.

STATEMENT OF CATHERINE R. PRICE, EXECUTIVE VICE PRESIDENT, MERCY SERVICES FOR AGING

Ms. PRICE. Thank you, I've never been told that my voice didn't carry.

Senator Riegle, on behalf of Mercy Services for Aging, I am Catherine R. Price, executive vice president. And prior to my current appointment, I have spent the last 21 years in the field of long-term care. Mainly I'm a Michigan native, born and raised in Michigan, but I spent those 20 years in the States of Pennsylvania, Maryland, West Virginia, and New Jersey in long-term care.

I am a registered nurse and I have been a nursing home administrator. So, the expressions that were presented this morning by the two care givers are a very, very common story to me. The tragic story that's repeated every day in many, many households across

this country. I am delighted and pleased that you have provided this opportunity for the residents of Michigan to provide you with information on catastrophic care and long-term illness.

First of all, let me give you a brief background on Mercy Services for the Aging. We are a subsidiary corporation of the Mercy Health Systems initially established 3 years ago as a collaborative effort between St. Joseph's Hospital in Pontiac and Mount Carmel Hospital in Detroit and as two divisions of the Sisters of Mercy Health Corporation. As they looked at how they could respond to the needs of the elderly, they were seeing increasing daily service in their field of acute care providers.

The Sister of Mercy operates 11 months in the State of Michigan and in keeping with the teachings of the Catherine McAuley, the foundress of the Sisters of Mercy, we began to look at programs a number of years ago on how we served elderly citizens, and many of our hospitals provide skill care, basic care. We provide housing services and congregate services that are community based services to seniors. We are currently under construction in a retirement community in Rochester Hills.

The retirement community consists of skilled beds, home for the aged beds, and a congregate of housing. I think it's important to point out here that that facility will provide what it can to those people who are medically indigent. It will, however, have to cover its debt services and therefore will not have available a lot of room for those people who have no resources.

I would like to speak briefly to your top diagram and call attention to the fact that long-term care is not long-term nursing home care. Long-term care as we perceive it is a continuing care. It is inclusive of all of the home maker services, the home health services, chore services, respite services and nursing home care becomes a fraction of that.

In the same mode, I would like to address the fact of who makes up the nursing home patient today. As you are aware, 45 percent of home in nursing homes receiving skilled and basic care are over age 85. That in itself has a very major message to be delivered to the American public. That is the fastest growing age group in this country in the demographics of aging.

The over 85 age population brings with it not only physical problems and health acuity problems, but many kinds of financial concerns. The family support, 72 percent of the elderly are still cared for by family and friends in this country. I think we can be proud of that and improve it. We don't have to kick ourselves because we're not taking care of our neighbor. Simply build on that and put some emphasis on it.

The 85-year-old, however has children who are themselves in the 60 to 65 age group, who are themselves living on limited income and retirement income. The grandchildren usually have children in college. So, there is a major financial impact that we will face in this country with the over 85 age population. But as a nation, we have known for 20 years and I think it's tragic that we wait until today to address it. If we don't address it now, we will never have addressed it. If we don't take care of our aging well in this country, we will not take care of our children well and we will not take care of our defense as well. [Audience applause.]

I would like to address the catastrophic care legislation and long-term care coverage. I have reviewed Senate Bill 1127 provisions. My main concern is that I think, once again, they will not touch on enough people. We need to have coverage that is broader.

The elderly people and I think most people in this country do not understand that Medicare does not care for the nursing home portion of long-term care insurance and many other services. According to the American Association of Retired Persons, seventy-five of their membership thought that Medicare would take care of nursing home care. In fact, Medicare pays for less than 3 percent of the days in the nursing home. Yet, this is a nation that has 20,000 nursing homes with over 1,600,000 people in bed each year and 1.2 million discharges and there is less than 3 percent of those on Medicare pay. Our elderly pay a heavy premium for that few number and do not get the services themselves.

I would like to call attention to the fact that I think there's a major need in how the Senate, the representatives of our Government and all of us as providers and public officials present what people get in coverage. I think that a major educational program has to take place in this country with every group that we can meet in helping them to understand what they have, not what they don't have. We have spoken on and on about Medicare and most people think they have something and that this promise has been held off but has never been delivered.

We do feel that under Senate bill 1127 it would be advisable for the Congress to expand upon the effectiveness of the Baucus Amendment, explicitly defining and mandating benefit standards for Medicare, supplement insurance contracts and to synchronize the effective date of the new standards with the effective date of the catastrophic care provisions of this act.

I should note that by-partisan legislation has recently been introduced in the Michigan House of Representatives, House bill 4648, which would require the Office Service to Aging to promote and coordinate and continue care for older persons. What I was talking about in terms of that 81 percent.

Senator RIEGLE. Right.

Ms. PRICE. I certainly do feel the 3-days elimination of hospital stays as a prerequisite for Medicare benefits for skilled nursing be dropped as a positive step. Our own hospitals have had experiences where the only reason the person was admitted was to qualify themselves for that three days care. It doesn't seem to be very cost effective and yet in some ways it becomes sympathetic with the fact that if they didn't do that, they wouldn't have any coverage and they would have lost the benefits.

Senator RIEGLE. Let me just say to you there, give you a piece of good news. Last week in the markup in the Senate Finance Committee where I am now a member of that Finance Committee as of this year and participating in the drafting of this catastrophic health insurance bill. I offered an amendment to do away with that 3-day requirement of having to be in the hospital before you qualified for skilled nursing home care. We had a little bit of a fight over it, but I was able to win that amendment of a unanimous vote after the debate was had. So, we solved that problem. [Audience applause.]

Ms. PRICE. While Mercy Service for the Aging believes that dedicating funds for the care of community based individuals is valid and has strong merit, I believe that the Medicaid Community Spouse Safety Net Act of 1987 introduced by Senator Barbara Mikulski of Maryland is a preferable alternative to the provision incorporated in Senate Bill 1127.

Under that act, it allows the spouse, it is an example of the individuals that spoke today, to maintain, to keep a maximum $25,000 of the couple's joint savings account of up to $35,000. It is a common experience to see elderly people caring for their spouse and bankrupting themselves in the process. And they then becoming the second member of that family to be dependents upon public funds within the Medicaid program.

It is traumatic emotionally, physically and financially. And sometimes it's hard to sort out whether the financial causes the physical or the physical causes the financial because of the emotion involved that's in that. I have had experience of seeing 75-year-old men return to a full-time job because they fell below the Medicaid allowance and they had enough income that they didn't qualify for Medicaid and not enough to care for the wife, go back to work full-time to be able to bring enough income tc support themselves after having retired.

In conclusion, I would like to tell you I appreciate this opportunity to be here, appreciate the focus; support strongly that something be done about the continuum of care for people, whether it be in the whole component of care, that we look to society as a whole to support their elders. Until we do that, we will not have done anything. Thank you.

Senator RIEGLE. Thank you.

[The prepared statement of Ms. Price follows:]

MERCY SERVICES FOR AGING

STATEMENT

by

CATHERINE R. PRICE
Executive Vice President
Mercy Services for Aging

before

THE HONORABLE DONALD W. RIEGLE, JR.
United States Senator

on

CATASTROPHIC AND LONG-TERM ILLNESSES

June 1, 1987
Ukranian Cultural Center
16601 Ryan Road
Warren, Michigan

INTRODUCTION

Senator Riegle, on behalf of Mercy Services for Aging, I am Catherine R. Price, Executive Vice President of Mercy Services for Aging. Prior to my current appointment, I was the administrator of health and residental programs serving seniors located in Pennsylvania, West Virginia, and Maryland. I am also the Past President of the Pennsylvania Association of Non-Profit Homes for the Aging and have been a member of the Executive Board and the Nominating Committees of the American Association of Homes for the Aging. By training, I am a Registered Nurse and have worked in an acute care hospital in Michigan.

I am delighted and pleased that you have provided this convenient opportunity for residents of Michigan to provide to you information on catastrophic care and long-term illnesses. I trust that my remarks will be helpful to you as you deliberate on and refine the benefit provisions of S 1127 and examine what our nation's public policy towards long-term care for the elderly should be.

First, let me give you a brief background on Mercy Services for Aging. Mercy Services for Aging, a subsidiary corporation of Mercy Health Services, initially was formed as a collaborative effort between St. Joseph Mercy Hospital, Pontiac and Mt. Carmel Mercy Hospital, Detroit, both divisions of the Sisters of Mercy Health Corporation. Its genesis was the realization that there was a need for housing and alternative health care options for the aging which were not being met with the current complement of acute care hospital services offered by the Sisters of Mercy Health Corporation.

As you may know, the Sisters of Mercy Health Corporation owns and operates 11 hospitals in Michigan including St. Joseph Mercy (Ann Arbor); Leila (Battle Creek); Mercy (Cadillac); Mt. Carmel Mercy and Samaritan Health Center (Detroit); Saint Mary's (Grand Rapids); Mercy (Grayling); St. Lawrence (Lansing); Mercy (Muskegon); St. Joseph Mercy (Pontiac); and Mercy (Port Huron).

In keeping with the teachings of Catherine McAuley, the foundress of the Sisters of Mercy, the mission of Mercy Services for Aging is to strengthen the Catholic health care ministry by fostering the dignity and independence of the aging, while maintaining a priority for service to the economically disadvantaged. We not only develop programmatic initiatives to serve the elderly but also work cooperatively with our hospitals so that they can properly respond to the needs of the elderly in their respective service areas.

ACTIVITIES OF MERCY SERVICES FOR AGING

Several of the Sisters of Mercy Health Corporation's Michigan hospital divisions offer nursing home services that are eligible for reimbursement under the Federal Medicare and Medicaid Programs. These include St. Lawrence in Lansing (220 licensed nursing home beds); Mercy Pavillion in Battle Creek (77 licensed nursing home beds and an additional 67 home for the aged beds); and Mercy Grayling (40 licensed nursing home beds). While these facilities provide an initial and partial link in the continuum -- from acute hospital services to skilled and basic nursing home services -- we are working on

adding to and strengthening this continuum and our commitment to meeting the needs of the aging population.

Presently under construction in Rochester Hills is a senior retirement community named Mercy Bellbrook. Phase I of this project, which will consist of 66 skilled nursing home beds, 55 home for the aging beds, and 144 apartments, is under construction, and we are anticipating occupancy in early 1988. If you were to take a ride out Avon Road, you would notice the steel girders protruding from the ground. We are about to commence Phase II, which will consist of 48-condominium style living units for seniors. Once completed, Mercy Bellbrook will provide for seniors a continuum of care from independent living to skilled nursing services, thus meeting the varied needs of the aging on one site.

Mercy Bellbrook, in order to be self-supporting, which it must be in order for us to meet our debt obligations, can only absorb a reasonably small percentage of Medicaid individuals and those able to make only partial payments for their care. Despite the fact that we are charging market rate rents to most of the individuals who will be residing at Bellbrook, we have sold it out several times over even though occupancy is over eight months away.

Heritage Place in Orion Township, a facility providing 58 federally subsidized apartments for low-income seniors, is currently under the operational aegis of the Orion Area NonProfit Housing Board. On July 1, Mercy Services for Aging will take over the management of this facility. The Sisters of Mercy Health Corporation, which was the original applicant to the

Department of Housing and Urban Development for this facility, has also been the successful applicant for funding for a similar housing facility in Highland Township of Oakland County. We expect groundbreaking this fall for this facility; once completed, this facility will provide 32 apartments for low income seniors.

CATASTROPHIC CARE LEGISLATION AND LONG-TERM CARE COVERAGE

Medicare Beneficiary Notification Requirements. I have had the opportunity to review S 1127's provisions as they relate to the activities of Mercy Services for Aging and to our philosophy of providing a continuum of care to the ever-burgeoning senior population. Abstracting, for a moment, away from the benefits incorporated into this law, I can only applaud S 1127's requirement to annually notify Medicare beneficiaries regarding the scope and perhaps more important the limitations of Medicare coverage. I have found in reviewing financial situations for those entering long-term care facilities, and it has been validated by survey data, that most Medicare beneficiaries believe, erroneously, that Medicare, or Medicare plus their Medicare supplemental coverage purchased in the private sector, will pay the average annual $22,000 cost for custodial care in a nursing home.

Baucus Amendment Modifications. I would also suggest, as part of your inquiry into catastrophic care, that you take steps to alter S 1127's proposed amendments to Public Law 96-265, more commonly known as the Baucus Amendment to Section 1882 of the Social Security Act. This law at present provides a cumbersome and awkward methodology for assuring that Medicare supplement contracts sold to seniors are not inappropriate. The General Accounting

Office's recent inquiry into the impact of the law, however, found that it was effective in protecting seniors against substandard benefit provisions and premium overcharges.

Should S 1127 or a similar variant become law, it would be advisable for the Congress to expand upon the effectiveness of the Baucus Amendment by explicitly defining and mandating minimum benefit standards for Medicare supplement insurance contracts and to synchronize the effective date of the new standards with the effective date of the catastrophic care provisions of this Act.

Under carefully crafted Congressional minimum coverage mandates, and appropriate effective dates, seniors would not incur gaps in their Medicare supplement coverage, a particularly critical consideration for those purchasing this coverage. Explicitly redefining such benefit standards would have a strong positive impact in Michigan since it is estimated that as many as two-thirds of our State's residents have Medicare supplemental coverage that complies with provisions of the Baucus Amendment. With such an explicit redefinition of benefits and retention of the loss ratio minimums in the Baucus Amendment, seniors will continue to be encouraged to supplement Medicare to the degree desired and the Baucus Amendment would continue to provide the protections identified by the General Accounting Office's analysis. This salutary change may not occur if it is left to the fifty states to make changes to their laws or regulations for Medicare supplement coverage contracts.

Study of Long Term Care Coverage Requirements. As part of the inquiry into what our nation's policy towards long-term care coverage for seniors should be, you may want to direct the Institute for Medicine to recommend to the Senate Finance Committee what minimum benefit standards and loss ratios should be provided in long-term care contracts that cover nursing home stays that are not eligible for reimbursement under Medicare.

Neither Indiana, Iowa, Michigan, or New York -- the four main states in which we operate -- have provided needed consumer protections or reasonable minimum benefit standards to purchasers of such long-term care coverage contracts. Hence many seniors, even those with the means to afford this coverage, are deterred from purchasing it. Congressional definition of minimum benefit standards will not only impart substantial consumer protections but it will greatly assist consumers when comparing what options best fit their needs. Further, such mandates will instill consumer confidence that will increase the number of individuals willing to make their own financial arrangements to provide for this care, thus reducing the pressures on public financing of long-term care.

I should note that bipartisan legislation has recently been introduced in the Michigan House of Representatives (House Bill 4648) which would require the Office of Services to Aging to "promote and coordinate a continuum of care for older persons." As part of our national policy development vis-a-vis long-term care, it would be highly desirable if each state were required to systematically address this issue for its own residents and develop

state-by-state policy options. At the very least, such analytic efforts will provide good data on what services and funding provisions are needed to meet the long-term care needs of seniors and other individuals.

Elimination of Three-Day Hospitalization Requirement as a Condition of Medicare Reimbursement for Skilled Nursing Services. Mercy Services for Aging strongly supports S 1127's provision to eliminate the three-day hospitalization requirement as a precondition to payment of skilled nursing services under Medicare. Several of our hospitals have admitted patients who did not meet the criteria for acute care hospitalization, but who were in the hospital for purposes of meeting Medicare's three-hospitalization requirement.

At least one of our hospitals has incurred expenses of over $70,000 in providing such care. While this is an unreimbursed cost, I suggest that the report mandated by Section 16 of S 1127 include an assessment of the reduction in the absorption of costs that hospitals must incur as a result of the current Medicare provisions. While such costs are not now accounted as Title XVIII costs, they should be counted as offsets to any added skilled nursing reimbursement costs under Title XVIII.

Impoverishment of Community Residents when Other Spouse is Placed in a Nursing Home for Which Services under Medicaid are Reimbursed. Section 14 of S 1127 requires that Title XIX plans be modified to reflect savings in State funds for Medicaid that would result from the passage of S 1127, and provides that, among other things, these monies be dedicated to increasing the

maintenance needs and monthly income levels for the community spouses of institutionalized individuals.

While Mercy Services for Aging believes that dedicating funds for the care of community-based individuals is valid and has strong merit, I believe that the Medicaid Community Spouse Safety Net Act of 1987 introduced by Senator Barbara Mikulski is a preferable alternative to the provision incorporated in S 1127. Senator Mikulski's bill will insure that senior couples, no matter in what state they reside when one of them is in need of nursing home care, will be treated across the country in the same manner. In addition, the benefits provided by her legislation are reasonable and provide that the community-based spouse will be able to keep a maximum of $25,000 of the couple's joint savings account of up to $35,000. Most of this amount must now go to pay for the institutionalized spouse's care. In addition, the Mikulski Proposal would guarantee that the community spouse would be able to keep a minimal personal allowance of $750 per month out of the $1,000 the couple receives. While these amounts are minimal, they will assure that community-based spouses are able to retain their dignity and maintain a reasonable living standard. These assurances cannot be provided under the provisions provided in S 1127.

Added Acute Care Benefit. We have examined the impact of the elimination of the $130 and $260 coinsurance requirements for hospital stays in excess of 60 and 90 days respectively. While I realize that these added benefits will accrue to only a few number of Medicare individuals per year, they will provide security and peace of mind to millions. For that reason alone it is beneficial. At present, the Sisters of Mercy Health Corporation

does not have a mechanism in place to provide you with quantification of the value of these provisions to our hospitals but we will be extracting and providing this data to you as soon as we have them compiled.

Assessment of Costs to Pay for Added Acute Care Benefit. Of especial concern to Mercy Health Services is a financing plan that is fair and does not provide harsh additions beyond the current $17.90 per month premium for Part B yet does not provide a disincentive for Medicare-eligible individuals to enroll in Medicare's Part B Program. The Catholic Health Association, to which we belong, has actively articulated before the Subcommittee on Health of the Committee on Ways and Means that the Stark-Gradison Catastrophic Care Coverage Plan provide a funding mechanism that provides appropriate premium equity safeguards to individuals purchasing this coverage. Mercy Health Services believes that your two-pronged increase of $4 per person plus an additional $12 per year increase for each $150 of income tax due after the first $150 is appropriate and has our support.

SUMMARY

To conclude, I have appreciated this opportunity and would be glad to respond to any questions you may have. Mercy Health Services looks forward to to working with you as the Senate Finance Committee's Subcommittee on Health further refines this bill. If we can provide additional quantitative data that will be of assistance, please do not hesitate to call on me.

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Education

St. Luke's Hospital School of Nursing
Marquette, MI, R.N.
West Chester State College, PA

Experience in Field of Services to the Aging

Tressler-Lutheran Service Associates, Camp Hill, PA
Vice President
Lutheran Home, Millersburg, PA, Administrator

Offices Held in Service to the Aging

Pennsylvania Association of Non-Profit Homes for the Aging, Past President; President, Vice President, Secretary; Public Policy Committee, Chairman; Long-Range Planning Committee, Chairman
NOR. PANPHA, Secretary; Education Chairman; Vice President; President

Offices/Committee Appointments Within The American Association of Homes for the Aging

House of Delegates, 1979-81
Executive Board, 1982-84
Nominating Committee
Professional Development Committee
Public Policy Committee
Subcommittee on Reimbursement, Chair
Membership Committee
Government Affairs Division
Health Committee, Chair, 1984
Awards and Resolutions Committee, Chair, 1986
Vice President, 1986-87

Senator RIEGLE. Thank you, let me have you stand right there. Thank you very much and I want to thank you as well for your very strong emphasis on home health care.

I had a note to myself to emphasize that and I've got so many notes in front of me that that sort of got to the side. But that's an essential item. And as you say in your phrase the continuum of care through all of the different aspects of which we will need care, it's very important to see it in all the stages and in particular that part.

I want to just ask you one question and then we'll go to our next witness. We have some people that have asked to speak, that after we finish with this panel we're going to then begin to call on those in the audience that have asked to make a statement.

Let me indicate—I have several that I'm going to just call on them in the order in which I've gotten their names. Anybody else that hasn't indicated on a sheet of paper that they want to speak, I'd like you to do so and I'm going to just ask the staff now to be around the sides of the room with pencil and paper so that if anybody wants to do that, you can in a line so we can call you up to speak and make what statements you wish. Let me just get you thinking along those lines.

But let me ask you Catherine this question. You estimate that approximately two-thirds of Michigan's beneficiaries now purchase Medigap insurance policies that we talked about earlier. Now, since this new Medicare catastrophic proposal that we're talking about here for the most part takes the place of the Medigap plans, what do you see as the most important benefits that should continue to be covered by private insurance?

In other words, as the Medigap changes or is there any long term in your mind going to be a need for Medigap policies and if there are, you know, where would you see the remaining need as being that they ought to be focused on?

Ms PRICE. Well, first of all, I would have to see how this new bill, how this new proposal works. You see, I'm a skeptic. I'll tell you that up front. Because I think that once again it's not going to cover what people think it is.

We have such overhead expenses in the Medicare Program that the cost of managing and operating the program as a system takes so many dollars that but never gets to the beneficiary in that nursing home bed or hospital bed. That concerns me, and I really would like to see that first of all that would actually float down on what kind of coverage that is there, I would be very hesitant to get rid of my Medigap programs until I found out that something equal or better replaces it. [Audience applauds.]

Senator RIEGLE. Thank you.

Now, Mr. Keeler, we introduced you earlier and we would be pleased to hear from you at this point.

STATEMENT OF JOHN KEELER, COORDINATOR, GERIATRIC PROGRAM DEVELOPMENT, HENRY FORD HOSPITAL

Mr. Keeler. Thank you, Senator Riegle. Before I begin reading my prepared testimony, I would like to comment that I know Char-

lie's situation very well because I am a former Director of Sheltering Arms and I know his wife Ruth.

On a daily basis, I would see between 22 and 25 older individuals that needed this respite type care and this day care situation. And I know Charlie's story very well and I know others' stories very well, and I would like to see more support in any of the bills that are presented for us in the adult day care situation program, both the social model and the medical model. There is a need for both. One should not be placed above the other, both programs are needed.

My purpose here today is to comment on the term catastrophic illness from the relative dimensions of an older person's financial situation and treatment technique provided.

The dream of civilized man throughout history has been to perfect the ability to relieve pain, reduce disability and extend the quality of life. It is ironic that today our combined medical knowledge and advanced technology are capable of nothing less than miracles, while our ability to manage the effective delivery of appropriate health services in a cost efficient manner often results in financial and emotional devastation for those most in need of assistance.

The 100th Congress is faced with perhaps one of the greatest challenges that our elected representatives have ever faced. You must develop a program that fairly addresses the needs of those individuals who during their lifetime have the misfortune to experience an illness that is beyond their financial resources.

Over the past 12 months various solutions have been proposed to protect persons from catastrophic health care costs. Our failure to date to arrive at a workable solution stems in a large part from our inability to arrive at a clear consensus about what the term catastrophic means.

As noted in Secretary Bowen's recent report to the President, most of us associate the word catastrophic with a relatively short term, acute, very expensive incident. Spinal cord injuries, third degree burns and organ transplants all conjure up the image of long hospital stays and huge hospital and physician bills.

Life threatening of fatal diseases such as cancer and AIDS are also perceived as catastrophic illnesses. Yet studies which have examined the characteristics of high cost patients in acute care settings have found that the more typical catastrophic patient is one who has a chronic condition that results in multiple hospital admissions over one or more years.

While most discussions of catastrophic illness expense have focused on hospital and physician charges, it is clear that for older people, an extended nursing home stay may pose the greatest threat of producing catastrophic health care costs.

Thus, if we define a catastrophic illness, injury or condition as any which produces large expenses under the treatment dimensions of hospital, physicians, or nursing home care, then it is clear that the solution must address expenses arising from both acute and long-term care.

Perhaps the more fundamental dimension is the issue of what is a catastrophic expense? Do catastrophic expenses occur when medical bills exceed a specific out-of-pocket dollar amount such as

$2,000, $5,000, or $10,000 or when they exceed a percentage of family income such as 5, 10, or 20 percent. Out-of-pocket expenses of $200 may be catastrophic to an older person living below the poverty line while a $2,000 out-of-pocket expense may be easily absorbed by his wealthy counterpart.

Although 95 percent of the elderly are covered by Medicare and two-thirds own one or more Medicare supplement or Medigap policies, it is often assumed that older persons are at little risk of incurring catastrophic health care costs associated with acute illness. However, limitations in Medicare coverage leave some older people exposed to significant costs.

Medicare's definition of a spell of illness, high co-payments after the first 60 days of hospital stay, a limited nursing home benefit with high co-payments after the 20th day, unassigned claims for physician payments and the lack of coverage for prescriptions, eye glasses and other health related expenses all contribute to high out-of-pocket expense for some individuals.

In 1983, 800,000 Medicare beneficiaries had net liabilities for $2,000 or more, not including the cost of Medigap premiums which range between $150 and $1,500 per year.

It is also widely assumed that Medicaid fills in the gaps for older persons who cannot afford Medicare supplement policies. About 13 percent of the elderly are in fact dually eligible for Medicare and Medicaid, but a full 20 percent of the elderly have neither Medigap nor Medicaid coverage. Not surprisingly, these individuals are below or near the poverty line.

Although the picture of catastrophic illness and expense is still blurred, it appears that a sizeable minority of the elderly are at risk of incurring acute health care expenses that exceed their ability to pay.

The liability for catastrophic long term care costs, which are typically considered separately from acute care costs is significant. Average nursing home costs exceed $20,000 per year with many facilities charging $25,000 to $30,000.

Currently, older persons and their families pay 50 percent of nursing home costs out-of-pocket. Many enter nursing homes as private paying patients but spend down their resources until they become eligible for Medicaid.

Today's elderly face a 40 percent risk of entering a nursing home in their lifetime. While not all admissions result in a long stay, an estimated 40 percent average 2. 5 years in a nursing home.

Because Medicare does provide some care in a nursing home, many elderly believe that their long-term care needs are covered. And if Medicare does not cover their long-term care needs, the elderly believe that their Medicare supplemental policy on their insurance provided to them as retired employees will provide them with coverage.

Reflecting the lack of correct information among consumers, the American Association of Retired Persons found that 79 percent of their members thought that Medicare or Medicaid supplemental policies would cover their stay in a nursing home. In actual fact, Medicare pays for less than 2 percent of all nursing home costs.

Focusing on acute care rather than chronic care, Medicare only covers short term care in skilled nursing facilities for a maximum

of 100 days. Even then, a co-payment of $61; $50 must be paid after the 20th day of confinement. Medicare supplemental policies usually pay for only this co-payment.

Although up to 100 days of nursing home care may be covered, the average Medicare covered stay in a skilled nursing facility is 30 days. Many elderly stay longer than 30 days but do not meet Medicare's rules for continued coverage. They must find other ways to pay for their nursing home care.

In conclusion, all of our skills in medical treatment and modern technology are wasted as long as lack of access and financial restraints restrict the ability of elderly individuals from compliance with appropriate treatment.

In order to assure that the two dimensions of needed treatment and an individual's financial situation are adequately addressed in the passage of any catastrophic health care package for the elderly, the following areas must be addressed:

One, prescription drug coverage. Seniors now pay over $8 billion each year on prescription drugs.

The second, Medicare buy-in. The Medicare premium, deductibles and co-insurance for all elderly and disabled beneficiaries with incomes below the poverty line would be paid for under Medicaid by the States.

Three, long term care. And there are two different areas that need to be considered when you look at the long term care issue. The first is Spousal Impoverishment. Policies which force one member of a couple into poverty when the other enters nursing home, must be eliminated. And the second, Home Health Care under Medicare for people recuperating at home must be expanded.

And the fourth area is progressive financing. Expanded coverage should not be paid for by a flat premium on all beneficiaries as the President has proposed. A progressive approach with protection for the poor and near poor should be used.

Thank you.

Senator RIEGLE. Thank you, very much. John, if you would just stay right there, please.

In your statement you mentioned the importance of including long-term care with the definition of "catastrophic health care" and that's a notion that I strongly agree with, and I think we're really getting a focus on that issue and problem here today.

My question is, How do you think we address that problem given the, really the huge expense of providing quality long-term care service? Some have estimated that that cost is maybe in the range of $40 billion a year and I realize, you know, that's the dimension and you do as well.

But do you have any thoughts as to how we might think about it or approach the issue of how do we pay that kind of bill?

Mr. KELLER. I guess if we could comprehend a project that would cost $1 trillion, we can surely comprehend a project that will only cost $40 billion. [Audience applauds.]

Senator RIEGLE. Finally, let me call up our next witness. Roberta, we're delighted to have you. Roberta, why don't you make your statement at this point.

STATEMENT OF ROBERTA HUMPHRIES, ADMINISTRATOR, ST. CLAIR HOME HEALTH CARE

Ms. HUMPHRIES. I am Roberta Humphries an Administrator of St. Clair Home Health Care. The health care partner of St. John Hospital in Detroit. I am also President-Elect of the Michigan Home Health Assembly. As the assembly spokesperson, I represent one hundred and twenty providers of home health care throughout the State of Michigan.

This group constitutes the majority of the certified home health agencies in the State of Michigan which are regulated and meet the standards of the conditions of participation for Medicare. Which does include criteria for coverage of services in a home and does cover standards for home health aids.

I think the testimony of the two caregivers that was given earlier graphically demonstrates what we see as providers of home health care. Perhaps more than any other group of health care providers, we are dramatically confronted with the devastating impact which catastrophic illness or disability can have on patients and families.

In the course of service delivery within the patient's own home environment, we daily witness the affects on patient, family, friends, and community. Catastrophic illness, disability, and long-term care not only have significant economic implications but a deep social and emotional impact.

The lack of a comprehensive plan to address catastrophic and long term care has caused family and friends to increasingly assume the burden of caregivers. As we begin to explore options to provide for catastrophic coverage, we need to assure that any plan considered covers both acute care and chronic long term illness and disability.

An effective proposal should feature home care as an integral component. Some of the initial proposals offered to Congress in recent months such as the one Health and Human Services Secretary Bowen presented do not include an expansion of home care coverage to meet these needs.

When properly administered, delivery of health care to patients in their homes is a cost effective alternative to institutional care. It is often the preferred setting for service, particularly by the elderly.

As community based providers, we recognize many barriers which inhibit the ability to maintain the elderly at home. We are aware that that Title XX funding has been frozen at the same level since 1984.

As Title XX is the source of funding for many noninstitutional based services aimed at assisting the elderly, such as homemaker services and home delivered meals, this erosion of Federal assistance jeopardizes the ability to provide the necessary support services to assure that the elderly can safely remain at home. With appropriate community support services, many elderly and disabled can remain at home versus placement in an institution.

As we also observe the elderly being required to pay an ever increasing percentage of health care costs out of their own pockets, we are concerned that they are faced with difficult choices. Do they

use their limited income to pay for groceries or the necessary prescription medications?

As the options for long term care and catastrophic coverage are explored, current issues relative to the health care delivery system must be resolved. We need to recognize and remedy the short comings of existing programs which are erroneously perceived to be addressing the needs of the elderly.

In the original Medicare Act of 1965, Congress wisely included a home health care benefit. With the exception of the elimination of an annual home visit limit, little has changed in the ensuing 22 years relative to the nature of covered service.

There is no doubt, however, that the needs of the elderly have changed dramatically, particularly with the advent of hospital prospective payment and earlier hospital discharge. In fact, what the home care industry has observed in recent months, is a constriction of the medicare home health care benefit.

Medicare recipients are being denied covered service through irrational and unreasonable determinations by fiscal intermediaries. Health Care Finance Administration directives concerning what constitutes medical necessity and intermittent care have circumvented the regulatory process.

Home health agencies in Michigan have experienced an increase in retrospective denial for services rendered to Medicare patients in 1986 from 2 percent to 9 percent. It is not only the industry that views this trend as unwarranted.

This is evident by the recent lawsuit filed against Health Care Finance Administration and Health and Human Services by seventeen congressmen, led by Congressman Harley Staggers. The American Association of Retired Persons recently joined in this action by filing a motion to proceed in a Friend of the Court capacity.

Several Members of Congress have responded to the attack against the Medicare Home Health Care benefit by introducing legislation which will assure the integrity and intent of the original benefit.

There are also a number of proposals now being considered which would include home care as an important element in any consideration for catastrophic coverage and long-term care.

We are aware, Senator Riegle, that you are one of the original co-sponsors of S. 1076, the Medicare Home Health Services Improvement Act of 1986, introduced by Senators Bradley and Mitchell on April 22. This legislation has several key components which would assure Medicare recipients access to covered services and protect provider's rights. We applaud your involvement in this effort and wish to express that we believe the intent of this piece of legislation is movement in the right direction.

I would like to add a couple of additional comments to what I had written here, and that is I would like to concur with what we talked about, long term care, that we not equate it with nursing home. That long term is a continuum of health care or any kind of community services are a very important element and should always be considered an important element.

And as you can see from time to time that I also concur that you cannot address catastrophic illness and avoid dealing with the issue of long term care. Thank you.

Senator RIEGLE. Thank you. I thank you for your statement. The Senate catastrophic committee is increasing home care coverage from 2 to 3 weeks a lot under current law to 45 days and the Senate proposal allows 7 days per week instead of the 5 that are currently allowed. I'm wondering if exchanges, obviously, goes in the direction we need to do.

But, I'm just wondering how you feel about that degree of improvement in the sense for the needs in this area?

Ms. HUMPHRIES. I don't see that this is an improvement. That is what they're already entitled. What that is is a mandate by Congress to assure that Medicare recipients get what they are entitled to. That is already part of a legislation, existing legislation.

Senator RIEGLE. So, you're saying—what further thought do you have in that sense then would your thought be that we ought to consider trying to go substantially beyond that now and with the thought that staying within the injunction of the President in terms of how it is to be paid for that we would pay for it either out of the supplemental benefit or out of the increase in the monthly payment or I'm wondering how much further you think we ought to try to go on that point? There's no set answer, but just your judgment about it.

Ms. HUMPHRIES. I think first and foremost, Senator, we have to insure that people are getting what they are entitled to today and that is one of the basic concerns and why I prefaced the way I did. They're not even getting what they're entitled.

As far as any kind of expense, I don't think we're into a position to financially analyze that without knowing what our current level of cost and what should our current level of cost be.

I don't know how familiar you are with how the way the Home Health Benefit is rendered, but it is a cost reimbursed program and we're reimbursed a settlement after a cost report on an annual basis. That process has been reviewed through the years and a number of changes have occurred in which it is very hard to analyze the home health data as a consequence because they have instituted some changes at one time while also denying covered services.

So, I think we have ourselves in a little bit of a dilemma there. I think that home health care can be an important part of any type of long-term care and there are important options there. I think what we need to do is we need to do some demonstration projects, as far as how it gets into the total picture and some of these have presently been instituted. In fact, there are some demonstration projects which are similar to the Weber Foundation.

Senator RIEGLE. Let me thank you as well for your testimony. Now, what we're going to do, we're going to go right on into the comments from the people in the room. I'm going to say to our panelist, again, how much I appreciate your participation today. I'm delighted to have you stay. I don't want you to feel the need to stay any longer unless you wish to. But I'm delighted to have you and you've really rendered an enormous service to everybody here, to our State, and our Country.

Mr. DIEKMAN. Senator, may I be excused, I have to get home to the wife?

Senator RIEGLE. Yes, thank you.

Let me now call to the microphone—I'm going to take these in the order in which we've received them. Dr. William Hoffman who is identified as the Director of the Social Security Department for the UAW.

Let me call two or three others to come down and perhaps be in line because we're going to have to go along here. I want to stick to the 3 minute comment rule, so we get through everybody.

The next person will be Doris Siefert, who is here from Detroit. I'd like her to be prepared to go next. Then Mr. Ralph Liborato, he has asked to speak. I'd like him to go next and then Chanda Hurkett who is here and she would be number four. So, if they could come down here to the front and be ready, we'll call on them in that order.

Dr. HOFFMAN.

STATEMENT OF DR. WILLIAM HOFFMAN, DIRECTOR, SOCIAL SECURITY DEPARTMENT OF THE INTERNATIONAL UNION, UAW

Dr. HOFFMAN. Thank you, Senator, I will be brief in summarizing my comments and I would ask that the full statement be included in the record.

Senator RIEGLE. We'll make all statements a part of the record.[1]

Dr. HOFFMAN. Thank you. First of all, I'm representing the UAW, the retired members and their families which constitute five million people across the country. We in Michigan are indeed very fortunate to have you as one of our Senators for the caring and approach that you've taken to the problems of individuals in this country, and we appreciate and applaud your leadership on this issue. We commend you for holding these hearings and I would like to just tell you a few of our concerns on the pieces of legislation that are before you.

Senator RIEGLE. Please do.

Dr. HOFFMAN. The Reagan administration has taken small and timid steps towards providing catastrophic expense protection. According to HCFA only half of 1 percent of the 30 million Medicare beneficiaries, fewer than 160,000 people will benefit from the proposal.

We urge that the legislators enact the package of improvements in Medicare which contain the following elements; removal of the limits on coverage for extended hospital days, elimination or at least drastic reduction of the $520 for the deductible, coverage of prescription drugs, especially maintenance drugs for chronic medical conditions a much lower stop loss than the $2,000; extension of the days of coverage and the reduction of the co-payment amounts under skilled nursing facility benefits.

We would also call upon Congress to begin to access and address the problem of inadequate services for the financial protection against long-term disability. We know that these problems are difficult, complex, and costly and that they are not amenable to a quick fix, but we've got to begin to at least address and access the program.

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[1] See p. 51.

Additional legislation is also required to combat the problem of balance billing. Charges by doctors beyond fees allowable under Medicare amount to a serious flaw in the shield protection against out-of-pocket expenses.

The issues of financing this new legislation are very high priority for the UAW and our membership. We believe sufficient revenues can be generated to pay the needed improvements by a number of steps.

One is to include expanding Medicare coverage to all employees of State and local governments. Second, additional savings can be achieved by recalculating the reimbursement rates of hospitals under the BRG reimbursement system; and third, we would believe in a premium based financing system with a provision to cushion the cost for low income persons. We would oppose any steps toward conversion of the Medicare Program to a means tested program.

Senator, there is one additional piece that I would like to comment on. Those responsible citizens in the country that have in fact negotiated coverage for Medicare, Medigap coverage I'll be taking through the collective bargaining process scarce resources and allocating them to cover our members and retirees, need a maintenance effort so that a windfall will not go to employers.

We have negotiated coverages for the kinds of protections that have been forthcoming in the legislation. We ask for maintenance of effort at least through, by the existing collective bargaining agreement.

Senator RIEGLE. Let me just say at that point, Dr. Hoffman, I raised that issue in the Senate Finance Committee last week. In fact, one of the last items we dealt with on the bill. I asked the chairman if he would agree that we would work on finding a way of doing exactly that between now and the time that the bill is brought up on the Senate floor. And he indicated a willingness to work with me and to commit the committee to work with me to make sure that we try to find an answer to that problem. So, we're acting on that one as well.

Dr. HOFFMAN. We appreciate your effort. In conclusion, what I would like to say is that even if we passed the existing legislation, I would like to call your attention to still thirty-seven million Americans do not have adequate access to health care. Most of these people are employed. Millions more are covered by inadequate insurance policies.

I started off in this business about 15 years ago thinking that national health insurance was a philosophical way to go. I'm privileged to represent Auto Workers in about forty States in collective bargaining areas and for 10 of those 15 years, I bargained in Canada.

Let me tell you it's not that we can't afford national health insurance in this country, we can't afford not to have national insurance in this country. [Audience applause.]

The cost of corporations on two sides of the border, it's about one half the cost in Canada for a full complete protection for their citizens as compared to in the United States.

Senator, thank you very much. We do commend you for holding these hearings and I would be available for any questions either now or in the future.

Senator RIEGLE. Thank you. Before you leave—he deserves that round of applause. And I think he knows, that we all know the leadership that the UAW has given over the years really pioneering in the labor movement to address the question of the health care needs of their members and families and have fought for those coverages in their contract negotiations as has been mentioned.

But there is something else that's very significant. I think the UAW deserves tremendous credit for the fact that while they've fought so hard to try to get health coverage for their own members and their families, they've always had a commitment and concern to try to get a health care coverage and program for every soul in this country, not just members of their own organization.

And I think that is a very exemplary and commendable aspect of them as an organization, that their concern is not just for their own, but their concern is for everybody out there who is facing the same problem. So, my hat is off to you in your role.

[The prepared statement of Dr. Hoffman follows:]

June 1, 1987

Statement of

William S. Hoffman, Ph.D.
Director, Social Security Department
International Union, UAW

on the subject of

MEDICARE CATASTROPHIC HEALTH INSURANCE

before the

Committee on Budget
United States Senate

On behalf of:

International Union, United Automobile
Aerospace and Agricultural Implement
Workers of America, (UAW)

SUMMARY OF UAW STATEMENT

The UAW supports enactment of legislation to provide Medicare beneficiaries with protection against catastrophic medical expenses. The UAW, however, has serious concerns about a number of the specific proposals which have been suggested.

Legislation is needed in response to several problems. The proportion of disposable income spent by the elderly for medical services is now greater than before enactment of Medicare; protection under Medicare has been seriously eroded in recent years as a result of cutbacks by the Federal government and medical care inflation; the private insurance industry has not been able to provide adequate Medicare supplementary coverage at an affordable cost to a large portion of Medicare beneficiaries; millions of beneficiaries and their families live in fear that financial catastrophe will accompany serious illness or injury.

The Reagan Administration proposal represents a small step toward addressing these problems. But it would provide significant help only to a miniscule percentage of Medicare beneficiaries. The UAW urges Congress to enact a legislative package which includes the following elements:

- a more meaningful benefit package to provide real protection, including prescription drugs, unlimited hospital stays, elimination or reduction of the Part A deductible and a lower "stop-loss" limit;

- steps by Congress to address seriously the problem of meeting needs for long term care;

- further measures to end "balance billing" by physicians; and

- appropriate and equitable financing arrangements, including expansion of Medicare to cover all state and local government employees; rebasing of the DRG reimbursement system for hospitals; a premium-related method coupled with some form of assistance for low income beneficiaries; and "maintenance-of-effort" provisions where catastrophic protection is now provided for retirees by their former employers.

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Senator Riegle, my name is William S. Hoffman. I am Director of the Social Security Department of the International Union, UAW. I appear before you today on behalf of some 1.5 million active and retired members of the UAW and their families.

I appreciate the opportunity to present our Union's views on legislation to provide protection against catastrophic hospital and medical expenses under Medicare. The UAW commends Senator Riegle for holding these hearings on a most serious national problem: financial devastation of thousands of disabled and elderly Americans due to the expenses associated with a catastrophic illness, as well as the widespread fear and insecurity among Medicare beneficiaries that such financial devastation could come to them and their families.

The Need

The UAW supports enactment of legislation to provide Medicare beneficiaries with protection against catastrophic expenses; however, we have serious concerns about a number of the specific proposals which have been suggested.

The prospect of such legislation represents a healthy and positive response to the following problems:

- The proportion of disposable income which the elderly must spend for medical services has grown in recent years so that it is now greater than before the enactment of Medicare in the mid-1960s.

- In recent years there has been an abdication of responsibility by the Federal government in regard to the health care of older and disabled Americans, and a corresponding shift of their health care costs onto private sector third party

payers, especially employers and labor unions, and onto the Medicare beneficiaries themselves. The proposed legislation would represent a reversal of this unfortunate trend.

- Protection under Medicare has been seriously eroded over the years as a result of cutbacks by the Federal government, plus incessant medical care inflation. For example, the Medicare Part A hospital deductible has risen from $40 at the inception of the program to $520 today.

- The private insurance industry has not been able to provide adequate Medicare supplementary coverage at an affordable cost to millions of Medicare beneficiaries. Some 30 percent of the elderly and disabled have no insurance coverage supplementary to Medicare. Even for those who can afford "Medigap" policies, their return in benefits is appallingly low — some 60 cents in real benefits for every dollar of premium, compared to a return of 98 cents on the dollar under Medicare. And Medicare does not have pre-existing condition clauses, which deny benefits to many senior citizens under private insurance policies.

- Millions of Medicare beneficiaries and their families are forced to live in fear that financial catastrophe will accompany serious illness or injury. It is unconscionable that so many older Americans must suffer from such insecurity and anxiety after a lifetime of hard work and sacrifice.

Proposed Measures

The Reagan Administration has taken a small, timid first step toward addressing these problems by endorsing the proposal put forward by Secretary Bowen. However, the $2,000 "stop-loss" limit on Part A and Part B expenses under the Administration's

proposal would only benefit the small number of Medicare beneficiaries who have an extended hospital stay. According to the Health Care Finance Administration, only 0.53 percent of the 30 million Medicare beneficiaries, fewer than 160,000 individuals, use coinsurance days (61 to 90 days of hospital care) or lifetime reserve days (60 non-renewable days for stays beyond 90 days) in a given year. Thus, the proposal would provide only about one in 200 Medicare enrollees with any significant help. Many thousands of other beneficiaries on limited incomes would be bankrupt before reaching the $2,000 "stop-loss". In addition, since expenditures for prescription drugs, long term care, dental care and preventive health services are not counted toward this maximum, all Medicare beneficiaries would still face the threat of devastating catastrophic medical expenses. While a small step in the right direction, the modest improvements proposed in the Administration's plan provide little basis for Medicare beneficiaries and their families to sleep more peacefully at night.

The UAW urges Congress to enact a package of improvements in Medicare which contains the following elements:

- Removal of the limits on coverage for extended hospital stays;

- Elimination or drastic reduction of the $520 Part A deductible;

- Coverage of prescription drugs, especially maintenance drugs for chronic medical conditions, which alone can amount to annual costs of catastrophic proportions to many individuals;

- A much lower "stop-loss" than the $2,000 figure in the Administration proposal; and,

Extension of the days of coverage and reduction of copayment amounts under the skilled nursing facilities benefit.

The lack of coverage for prescription drugs, especially maintenance drugs, is a particularly glaring inadequacy in the current Medicare program. The UAW strongly recommends that outpatient prescription drugs be covered under Medicare as part of a package to protect elderly and disabled beneficiaries from catastrophic medical costs. Our experience indicated that it is possible to establish an outpatient prescription drug program under Medicare which is affordable, with predictable benefit expenditure and relatively inexpensive administrative costs, and which would enhance the quality of medical care. The program can either be full service or more limited, covering maintenance drugs, perhaps through a mail order approach. Generic substitution should be included to limit costs. Selective contracting with provider organizations should also be explored. Quality can be promoted through utilization review mechanisms which include patient and physician profiles designed to identify specific problems and aberrant prescribing patterns. The UAW recommends against adoption of a "major medical" approach because of high administrative costs and a loss of benefits due to the involvement of patients in claims processing and recordkeeping.

The UAW also calls upon the Congress to begin to assess and address the problem of inadequate services for and financial protection against long term disabilities. Medicare does not now cover such services, contrary to the mistaken belief of many citizens. The Administration's proposal does not include it, also contrary to what many believe. We know that these problems are difficult, complex and costly. They are not amenable to a quick fix because of several factors. The need for long term care is not necessarily a result of age, but rather is a result of dependence related to disability that can and does occur at any age. Long term care encompasses a variety of services

including home health care, adult day care, other medical and social services and traditional nursing home care. Services are best when designed to help the patient maintain independence.

Developing a long term care policy must begin with the acknowledgement of society's responsibility to care for those who have become disabled and can no longer care for themselves. Such policies must be comprehensive, with funding from a variety of public and private sources. Services and facilities must be required to meet minimal standards of quality, and these must be effectively monitored and evaluated to ensure compliance. The UAW urges Congress to begin a serious assessment of long term care needs and to map out a plan of action to address these crucial needs.

Additional legislation is also required to combat the problem of "balance billing" by physicians treating Medicare beneficiaries. Charges by doctors beyond fees allowable under Medicare would not count toward the "stop-loss" limits under proposals by the Administration and others. Such overcharges amount to a serious flaw in the shield of protection against high out-of-pocket expenses. Measures to mandate or seriously strengthen assignment by physicians under Medicare need to be enacted in order to prevent dilution of the intended protection.

Financing Issues

The issue of financing improvements in the Medicare program is of serious concern to the UAW, as it is for other labor and senior citizens' organizations and advocates for the disabled. The accumulated and prospective budget deficits, which represent one of the most enduring legacies of the Reagan Administration, greatly complicate the search for adequate and progressive financing. The UAW believes that

sufficient revenues can be generated to pay for needed improvements in the Medicare program by taking a number of steps.

First, additional revenues can be realized by expanding Medicare coverage to include all employees of state and local governments. This is a long overdue step which would further the goal of making Medicare a truly universal program.

Second, additional savings can be achieved by recalculating the reimbursement rates for hospitals under the DRG reimbursement system. The recent study by the GAO suggests that the profit margins of many hospitals are sufficiently high to justify a "rebasing" of the DRG system. The study showed that the 1985 hospital profit rates from PPS averaged 15.27 percent, up from 14.18 percent in 1984. This comes out to over $1 million per hospital in 1985. During the same time period Medicare inpatient discharges decreased by 5.63 percent. Most of the profit increase is due to the fact that the PPS federal rate was based on overstated hospital inpatient operating costs. Also, the GAO studies indicate that data used to set prospective payment rates included the cost of unnecessary services and/or inappropriate cost elements.

Third, the UAW supports a premium-based financing system with a refundable income tax credit, or some other provision to cushion the cost to low income persons. We are willing to work with Congress on the specifics of such a proposal. The principal point is to protect lower income elderly Americans, who too often now cannot afford both food and heat, from the hardship represented by even a relatively modest increase in the Medicare Part B premium. As a result of Administration initiatives, there have been large increases in Medicare premiums in recent years; it is time to reverse this trend by changing the existing basis for premium-sharing in the Medicare Part B program. A return to the prior-law standard under which Medicare Part B premium increases

were linked to cost-of-living adjustments in Title II of the Act would provide substantial relief to all Medicare beneficiaries.

The UAW strongly opposes proposals to tax a portion of the actuarial value of Medicare benefits. This would establish an unfortunate precedent for taxing all health care benefits provided by employers to their workers and retirees. As you will recall, the UAW and other unions, as well as a broad segment of the business and insurance community, strenuously opposed such proposals when they were advanced by the Administration in the context of the tax reform legislation in the last Congress. We believe Congress made the right decision in rejecting such proposals at that time, and we see no reason to reverse that policy now.

Taxing Medicare benefits would also result in a substantial tax increase for a large portion of the elderly and younger disabled people and their families. The imposition of such a tax increase would be particularly unfair to those senior citizens and younger disabled workers who, in many cases, already receive protection against "catastrophic" medical expenses through insurance policies that are entirely paid for by their employer. This is the case for the vast majority of UAW retirees. The net result of such proposals to finance Medicare improvements by taxing the actuarial value of Medicare benefits would be to shift the cost of this protection from employers onto Medicare beneficiaries. We believe that this type of cost shift cannot be justified.

The UAW is concerned that the taxation of Medicare benefits would undermine support for the Medicare program. It is important to recognize the distinction between taxing cash income, such as Social Security benefits, and extracting taxes from individuals for in-kind services, such as health benefits, which only have some imputed actuarial value and do not represent any increase in cash income. In our judgment, there would

be strong resistance among the elderly to the imposition of new taxes on Medicare benefits, since the beneficiaries are not receiving any cash income and may not even use the health care benefits in any given year.

The UAW also opposes any steps toward conversion of Medicare to a means-tested program. This does not mean that we would oppose certain forms of progressive financing, but maintenance of Medicare as a non-means tested element of our social insurance fabric is essential.

Finally, the UAW asks this Committee and the Congress to recognize that millions of retired Americans, including the vast majority of UAW members, now have Medicare supplementary policies, paid for entirely by their former employers, which provide essentially the same or better protection as that which is proposed here today. The Administration plan, and other proposals, if not otherwise adjusted, would result in a windfall reduction in liability for many major corporations and a corresponding shift in cost, through increased premiums, to Medicare beneficiaries. The UAW fought hard to get employers to provide Medicare supplementary coverage originally and there is no reason now to shift the costs of paying for these benefits onto beneficiaries. We trust that such an inequity could not be intended by the Congress. Therefore we think that the inclusion of a "maintenance-of-effort" provision which would require employers to continue to contribute toward such coverage for a period of time, such as for the duration of existing collective bargaining agreements, is an essential component of any Medicare catastrophic proposal. We are prepared to work with the Congress on the specifics of such a provision to avoid unfair cost shifting from employers to Medicare beneficiaries.

Summary and Conclusion

The UAW strongly supports enactment of improvements to Medicare to protect beneficiaries against catastrophic medical expenses. We urge this Committee to develop a legislative package which includes the following elements:

- a more meaningful benefit package to provide real protection, including prescription drugs, unlimited hospital stays and a lower "stop-loss" limit;

- steps by Congress to address seriously the problem of meeting needs for long term care;

- further measures to end "balance billing" by physicians; and

- appropriate and equitable financing arrangements, including expansion of Medicare to cover all state and local government employees, rebasing of the DRG reimbursement system for hospitals, a premium-related method coupled with some form of assistance for low income beneficiaries, and "maintenance-of-effort" provisions where catastrophic protection is now provided for retirees by their former employers.

Even the enactment of such a package would do nothing to provide health care protection for some 35 million Americans who currently lack any health care coverage, most of whom are employed workers. It would do nothing to provide protection againt the cost of catastrophic illness for millions who are covered by inadequate insurance policies. These problems ultimately only will be resolved by the enactment of universal and comprehensive national health insurance.

The UAW would again like to thank Senator Riegle for the opportunity to present our views on this important subject. We are anxious to work with the Congress in developing a package that will provide these much-needed improvements to the Medicare program.

Thank you.

Senator RIEGLE. Doris Siefert, are you ready to go?

Ms. SIEFERT. Yes, sir.

Senator RIEGLE. Thank you, please come right up. To be followed by Ralph Liborato.

Is Chanda available?

Ms. HURKETT. Yes.

Senator RIEGLE. All right, you'll be next, and then Pat Sherman. Doris, let us hear from you now.

STATEMENT OF DORIS SIEFERT, CO-CHAIRPERSON, TASK FORCE OF NATIONAL HEALTH SERVICE FOR THE METRO NORTH GRAY PANTHERS

Ms. SIEFERT. I'm very, very happy that you called this hearing and I'm sure you're as gratified as we all are to see what the turn out has been, surprising and it does say something very important.

My name is Doris Siefert and I'm co-chair of the Task Force of National Health Service for the Metro North Gray Panthers. The Gray Panthers has an intergenerational membership, close to a 100,000 and rapidly growing. About a third of them are young people.

So, I would like to expand the dialogue a bit. It fortunately relates to what Dr. Hoffman and you have said before. Our local co-convener; for example, is about thirty-three.

Senator Riegle, Gray Panthers has endorsed none of the current catastrophic plans. We're sorry, but they don't make it. Rather, we believe that quality health care is a right for people of all ages. [Audience applause.]

Not merely for those of us on Medicare. We need to be bold, and we need to expand our horizon a bit. Catastrophic and terminal illnesses are not a monopoly of senior citizens. Consider the tragic death of newborns whose parents couldn't afford adequate prenatal or post-natal care. Citizens of all ages are victims of diabetes, multiple sclerosis, CP heart ailments, kidney disease and the like. And families are forced into emotional and economic bankruptcy by the present soaring cost of medical care.

It's no great surprise then that in recent exit polls, 75 percent demanded a national care system even if it meant more taxes. [Audience applause.]

The United States and South Africa, if you find this strange, I do, are the only two industrialized nations of the west who do not have a national health program. In the United States, 40 to 50 million have neither public or private health care coverage. Over half of them are among the employed, those who are working; that is, about two-thirds of them don't have coverage.

That's growing in this part time political world we find ourselves in. The corporations don't hire full-time fringe package people any more. Part-timers, no fringe, no coverage. Almost a million of those who have no coverage live right here in Michigan.

I will take the trip that Dr. Hoffman did across the river to Windsor. In Ontario their preventional federal plan covers an entire family health care, and I mean short-term and long-term medical needs, for $59.50 a month. The Province picks up the tab for the unemployed or otherwise indigent.

When you turn 65 over there, no more premiums, but your comprehensive benefits continue. Popular support for the program is so strong in Canada it's triumphed time and time again over challenges by the medical lobby.

More recently, by American corporations seeking to discredit the Canadian system and even more recent you've seen it in the press recently, the efforts here to polarize the young against the old. That is a sad commentary when people organize to pit the young against the old, claiming that we are an enormous burden on them and on their future. On the contrary——

[Audience applause.]

Ms. SIEFERT. On the contrary, we have great concern over them, for them and their futures. How are they going to pay these extraordinary premiums for health care coverage? What happens when elders in their family become ill? Somebody is going to have to pay for it. Private insurance premiums are out of reach.

Gray Panthers has joined with several national coalitions in advocating a national health care program, Senator Riegle, physicians organizing public health administrators, health workers, labor unions and hundreds of grass roots organizations have demanded a halt to that chaos on barbarism of health care for profit instead of people. [Audience applause.]

I would like to conclude with a short quote. And by the way, I should brag a little bit. Petitions in the Senior Citizen News have found, included with your recent additions, petitions have been circulating by several cross-country organizations asking for national health care. These programs of band-aids are fine, but what we need to do is come up to the twenty-first century with a modern program that's fair and equitable. We just started. I think there were a hand full of us Gray Panthers who took this petition. People were chasing us for the privilege of signing, I kid you not.

I want to quote Wilber Cohen. We all feel a tremendous loss of the former Secretary of Health, Education and Welfare. He was an insightful, a knowledgeable person, and on sight observer of the health care seen in America. Mr. Cohen said: "Covering every individual from the day of birth to the moment of death is not only necessary and desirable, but inevitable."

And I saw something recently, the editor of that prestigious journal, the New England Journal of Medicine foresaw that we would have a plan by 1995. I think that's very encouraging.

For the present, politically, I thank you for the opportunity to express the Gray Panthers' point of view. I would hope your support would extend to influencing your colleagues in Congress to advocate support, co-sponsor the only bill that right now comes even close to satisfying what we need in this country and that is House Bill 2402, a reintroduction by Congressman Ron Dellums of California, a comprehensive national health care bill.

Thank you.

Senator RIEGLE. Thank you. Let me ask at this point, again, and we're going to go on down through the list. I'm going to ask my next speaker to come forward. How many of you by a show of hands would support the idea that's just been advanced, that we need to have a national health care system?

The AUDIENCE. Yeah, yeah, [showing of hands.]

Senator RIEGLE. That's a very substantial showing. I appreciate you for raising your hands.

Mr. Ralph Liborato.

STATEMENT OF RALPH LIBORATO, SECRETARY OF TREASURY, AFL–CIO

Mr. LIBORATO. Senator Riegle, I am pleased to say that Tom Turner, President, and other fellow officers and members of the AFL–CIO appreciate your kind invitation to express our view points in a matter of catastrophic health insurance coverage for senior citizens. It is in this regard that they have selected me, Ralph Liborato, in my capacity as Secretary of Treasurer as spokesman of today's meeting.

We long recognized the need to provide proper health care not just for those who can afford it, but for all our citizens. The present Medicare system which was designed in the 1950's will offer health care coverage for our senior citizens is now in need of revision.

When it was originally implemented, it did not take into account the many improvements and advancements of medical treatment we have had over the last 20 years. Medical science has found new ways during that time to treat chronic conditions previously untreatable and to prolong life so the life spans will grow. But along with improvements have come increased health care costs which Medicare was never financially equipped to cover.

Now, many of our senior citizens which rely on Medicare as our sole source of health insurance; often one serious illness can result in financial ruin. Medicare has limitations on payment and many times benefit payments can be exhausted long before treatment is completed. Additional, essential services such as preventive care, eye glasses, hearing aids, prescription drugs, substance abuse and long-term care are not covered by the program.

While most of the above-mentioned services are costly, it is the area of long-term care that is the need most critical. According to recent studies, once an individual reaches the age of 65, there is a one in five chance that they will need some form of nursing home care.

Medicare does not cover the cost of long-term care in many cases nor does it qualify for some type of coverage. Individuals and their families must deplete their life savings, sell most of their belongings and if they're receiving Social Security benefits, they must turn over a large portion of their monthly checks to pay for that cost. They must compromise themselves before qualifying for certain guidance and assistance.

The need for review and revision of the program will continue. The so-called baby boomers of the post World War II era have created a significant statistical vote in the population charts, so that in 20 years that laxed group will begin to put an even greater strain on an already out-dated system. The time to make necessary changes is now in order to help many bring relief to those individuals who are already caught in an unfair and expensive system.

The AFL–CIO has taken a position that catastrophic health insurance is of vital importance to the American people. We realize, of course, that there are great costs associated with the implication

of such a policy. It is our belief that any system created must take into account an individual's ability to pay. We feel that a premium based system with a refundable tax credit for low income beneficiaries is one approach. There is precedent for this.

Congress has already provided an earned income tax credit to low income single parents. Providing protection against catastrophic illness is an important step, but we would urge you not to limit action to acute care only. Medicare should be expanded to cover all the central medical services; such as, preventive care and prescription drugs.

We are encouraged by your efforts. It is our hope that eventually a fair policy providing affordable medical care for all our people will be obtained.

Thank you Senator Riegle. I am glad to say that the Metropolitan AFL-CIO looks forward to working with you to achieve our common goal, the whole matter of catastrophic health insurance coverage for senior citizens.

Beyond our written script, let me just tell you, I am happy that you're our Senator in Washington.

Senator RIEGLE. Thank you very much. Mr. Liborato. Before you leave let me just say that your leadership over a long period of years has helped the seniors and everybody else and it's a great pleasure to have you here today.

Mr. LIBORATO. Thank you, Senator.

Senator RIEGLE. Our next witness is right down here at this microphone, and I would like to draw your attention to her. Why don't you raise your hand so they can see you here.

This is Chanda Hurkett and she is here in a motorized wheel chair. She was kind enough to come out today and she's got a statement to make and we would be very honored to hear it now.

STATEMENT OF CHANDA HURKETT

Ms. HURKETT. Senator Riegle, I have submitted some written testimony to go into the record.[1] Above and beyond that, I have a few statements. At the age of 17 I broke my neck. At that time, my mother was 50 and my father was 67. And I have heard many testimonies here today about the impact of catastrophic illness on seniors. For a parent to face having a child with a spinal cord injury is devastating.

I watched the deterioration of my father and my mother as they cared for me. As I have become more independent and self-sufficient, I watched my father's life savings go out the window to take care of my care. My father is now deceased, my mother is 62. She herself is looking at the Medicare system. She will have to face that.

I presently am covered by both Medicaid and Medicare. People believe that when you have Medicaid and Medicare, your needs are met. This is not true. Medicaid sets limits of what they feel are necessary supply limits per month, Medicare sets limits.

Medicare limits are set lower than the State of Michigan's Medicaid limits. In order to bill Medicaid for any type of medical

[1] See p. 67.

supply that is needed, any supply that is needed and also cover under Medicare, Medicare must be billed first. When I use supplies, medical supplies that run a gamut due to my injury that surpass the Medicare limits, Medicaid will not pick up any of the balance. There is a catch-22 to Medicare Medicaid coverage.

I have worked long and hard to complete my degree. I'm very close to that and I'm looking forward to going into the working world. There are further problems there. People with spinal cord injuries can become participants instead of dependents on the system and they're willing to. The problem is the medication, the medical supplies that are needed and that are covered under public benefit offered by employers.

It's my hope that in drafting a new catastrophic health care coverage, some sort of provision will be made for people who are looking at leaving the system in the future and wish to seek employment and not be dependent upon the system.

Thank you.

Senator RIEGLE. Chanda, let me say that I consider that to be some of the most valuable testimony that we have had today. I will just say to you personally that I will work on that specific item directly, and we're going to see if we can't find some better answer for it. Also, I really appreciate your coming and illuminating it for us.

Ms. HURKETT. Thank you.

[The following was supplied for the record by Miss Hurkett:]

Chanda Hurkett (313) 977-2485
32915 Ruehle
Warren, MI 48093

Diagnosis: Complete C-6 quadraplegia, nuerogenic bowel & bladder, complication of the medial aspects of ankles, osification of the hips.
Prognosis: Good

Benefits: Medicare (exhibit A)
Blue Cross/Blue Shield Medicare Suppliment (exhibit B)
Medicaid (exhibit C)
Social Security (Exhibit A)

Doctors: Dr. William Waring
Dr. Fred Maynard
University of Michigan Hospital
Dept. of Physical Medicine & Rehabilitation
1500 East Medical Center Drive
Ann Arbor, Michigan 48109

Dr. Dale Drew
St. Joseph Mercy Hospital
Dept. of Uriology
900 Woodward
Pontiac, Michigan

History of injury:
December 27, 1974 I was in a swimming accident which resulted in the fracturing of the C-5, C-6, and C-7 vertebras of my spinal column. During acute care, decubiti formed on both feet, resulting in chronic bone, muscle, and skin problems.

History of rehabilitation:
In 1975 following three (3) months of acute care for my spinal cord injury (SCI) at Beaumont Hospital of Royal Oak, I was transfered to St. Joseph's Hospital and received six (6) months of rehabilitation. In 1982, I entered U of M Hospital for surgery, and subsequently received an additional five(5) months of rehabilitation.

History of benefits:
At the time of my injury I was covered by my father's Master/Major Medical Blue Cross/Blue Shield. In April of 1977, I was placed on Medicare, with my father's insurance covering all treatments, medication, medical supplies and subsequent medical expences. Upon my father's death in 1981 no provisions were included in his Blue Cross for survivors benefits, and I was forced to apply for Medicaid to meet my daily basic needs for medications and medical supplies. It was at this point I became all to familiar with the inadequacy of health care insurance currently available to individuals with catastrophic injuries or illnesses.

Problems with the system:

When people hear that you have both Medicare and Medicaid, they assume that all of your medical expences are met by the coverage. This is far from the truth. As a result of my injury I require many medications and medical supplies. Some supplies are covered only under medicare, others are covered only under medicaid, and yet others are covered by both. (Please reffer to exhibit D) Medications, those which are covered are only covered by medicaid.

The major problem I encounter with the system, is the interaction between medicare and medicaid. On any medical supply that is covered by medicare, medicare will pay 80% of the cost, to a reasonable level, and my Blue Cross/ Blue shield Medicare suppliment will pay the 20% balance. However, Medicare has set a limit of how many units of a supply I am entitled to a month, similarly Medicaid has set a monthly limit. (Exhibit E) In order to bill Medicaid, Medicare must be billed first, then Blue Cross/Blue Shield and lastly Medicaid. If the units of supplies I use exceeds the limits set by Medicare Medicaid will not pay any remaining balance. This is easier illustrated: Medicare allows 2 urinary drainage bags a month. Medicaid allows 10 per month. Since the supply is covered by Medicare, they are billed first, and will pay 80% of the cost of 2 drainage bags. Since medicare OK'ed the 80%, BC/BS will pay the 20% balance on 2 bags. The problem arises because I use 4 bags per month, and Medicaid will not pick up the balance for the necessary, remaining 2 bags even though they would allow me 10 bags if they were my only coverage.

Another area which presents a problem to me is the selection of which drugs will be covered by medicaid. I require medication which is not covered and is quite expensive. (Exhibit D)

A spinal cord injury also impacts heavily on an individuals psychologic stability, as well as his role in social and familiy settings. As is pointed out in the letter from Dr. Roth (exhibit F) psychological counselling is imparative for the victim of a catastrophic illness. No coverage is available for out patient psychological treatment under the current system.

Under the benefits I am receiving presently, after the bills for my necessary medications and supplies are paid, I have virtually no income to cover food, clothing, and shelter. (please refer to exhibit G)

I am currently completeing my degree at Wayne State University, and am hopeing to find employment upon graduation. However, with the current health insurance coverage available to individuals with catastrophic injuries it will be difficult.

As I draw closer to graduation, I am faced with the fact that any job I accept will have to offer high compensation to cover the medical expences which are currently being met by the Medicare/Medicaid system. The system has created a disincentive for leaving, due to the inadequecies of insurance available to victims of a catastrophic injury.

I have worked long and hard to reach a level of independance and education that will allow me to become self sufficent. Medicare and Medicaid have helped me reach this level, and I am thanful for that. However, the many problems within the system, would have made it impossible to reach this level without putting a burden on my parents.

As I stated before, I am hopeful in gaining employment, but if I prove to be unsucceaful, I am fearful for my future. The burden which my late father, and my mother have shouldered is now mine. I will go forth willing to assume all the consequences, and shall be hopeful that in your efforts to help the catastrophicly injuried a better system will be in place for those who follow.

Individuals with spinal cord injuries are capable of being valuable citizens rather than a strain on the social--welfare system.

Sincerely submitted,

Chanda Hurkett

Chanda Hurkett,
June 1, 1987

Social Security Benefit Information

EXHIBIT A

From: Department of Health and Human Services
Social Security Administration

Date: May 28, 1987

Telephone No.: (313) 963-1500

Chanda Harkett
32915 Ruehle
Warren, Mich 48093

Information about a person's Social Security benefits is confidential by law. Except under certain circumstances specified by law and regulations, the Social Security Administration does not reveal such information to any person except the beneficiary involved, or his or her authorized representative.

Attached is the information you requested about your benefits. The attachment is an official record of your Social Security and/or supplemental security income benefits as of the date of this letter. You may use the attached information for proof of benefits.

If you have any questions concerning this official record, please contact your local Social Security Office.

Calls to this number are monitored; however, the calling party has the right to request that the call not be monitored.

SIGNATURE AND TITLE OF AUTHORIZED OFFICIAL

TITLE	SIGNATURE
Detroit, Teleservice Manager	Pat C. Mastrodomenico Pat C. Mastrodomenico

SOCIAL SECURITY OFFICE ADDRESS: Department of Health and Human Services
Social Security Administration
13780 E. Fourteen Mile Road
Warren, Michigan 48093

211

* U.S. Government Printing Office: 1986—491-573/60179

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STATUS   MBR YES LOU-05/21 SSACCS NO  LOU-05/22 SSR YES LOU-03/02/84
INPUT SOCIAL SECURITY NUMBER 365-64-5575    NAME  C HURKE      USER CODE 211
3RD PARTY QUERY CONFIDENTIAL SOCIAL SECURITY DATA - CLAIM NUMBER 378-05-3156C2
INDIVIDUALS OWN SOCIAL SECURITY NUMBER: 365-64-5575
  CHANDA R HURKETT FEMALE BORN:04/30/57  ENTITLED:04/75
  CHANDA HURKETT          32915 RUEHLE           WARREN MI 48093
PAYMENT STATUS CODE: C -BENEFITS PAID
NET MONTHLY BENEFIT IF PAYABLE: $371.00
BENEFIT HISTORY:
 DATE:       GROSS BENEFIT:
 12/86      $388.90 CREDITED
 05/86      $384.50 CREDITED
MEDICARE DATA            ENTITLED PREMIUM
HOSPITAL INSURANCE         04/77  $  0.00
SUPPLEMENTAL INSURANCE     04/77  $ 17.90
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MSG 4792537 PAGE  02

MSG-4792537 DTE-05/23/87 TPQY  DAN-365-64-5575   ID-HURKE UN-211 PG-002
INPUT SOCIAL SECURITY NUMBER 365-64-5575    NAME  C HURKE      USER CODE 211
3RD PARTY QUERY CONFIDENTIAL SUPPLEMENTAL SECURITY INCOME DATA ON 365-64-5575
ATTN: INFORMATION FROM INACTIVE SSI RECORD
  CHA R HURKE
APPLICATION DATE: 07/25/75 TYPE OF PERSON: DISABLED INDIVIDUAL
CITIZEN/ALIEN CODE: U
PAYMENT STATUS CODE: T31 - TERMINATED BY SYSTEMS ACTION
```

EXHIBIT B

Blue Cross
Blue Shield
of Michigan

600 Lafayette East
Detroit, Michigan 48226-2998

Date: May 21, 1987

To: Chanda Hackett
32915 Ruehle
Warren, MI 48093

RE: Supplement to Medicare

Contract Number: 402-286-821

Group Number: 99999

This letter is to verify coverage through Blue Cross and Blue Shield of Michigan for the above subscriber.

Calendar Year of: 1987

Effective Date: 1/10/87

Contract Paid to Date: 7/10/87

Monthly Premium: $42.47

One Person Two Persons Full Family

Sincerely,

Customer Telephone Services Department, #0202

DF 5748 Feb 82

EXHIBIT C

50 20 12 04
29600 CIVIC CENTER
WARREN, MICHIGAN 48093

31187886
33828

MICHIGAN DEPARTMENT OF SOCIAL SERVICES
MEDICAL ASSISTANCE AUTHORIZATION

06/01/87 THRU 06/30/87

RECIPIENT ID NO	ELIGIBLE PERSON	BIRTH DATE	CK
THIS PROVES YOUR VEHICLE IS EXEMPT FROM EXHAUST TESTING. INFO--CALL (313) 964-3095.			
24675500	HURKETT CHANDA R	043057	94
SS CLAIM #378053156C2			

HURKETT CHANDA R
32913 RUSHLE
WARREN MI 48093

PROG	CEP	CASE	UNIT	WKR	CASE NUMBER
P	50	20	12	04	30112805A
DEGREE OF COVERAGE					
2					

DSS-4470 (REV. 12-86) PREVIOUS EDITION ARE OBSOLETE

EXHIBIT D

BASIC REQUIRED MEDICAL SUPPLIES

SUPPLY (MONTHLY)	# REQUIRED	PRICE	COVERAGE
Indwelling catheter	2	$ 4.55	Medicare/Medicaid
Catheter insertion tray	2	$ 6.60	Medicare/Medicaid
Urinary drainage bag	4	$ 9.50	Medicare/Medicaid
Urinary leg bag	4	$ 4.25	Medicare/Medicaid
Gauze pads, nonsteril 4"x4" (25 ct. pkg./box)	2	$ 4.55	Medicaid
Alcohol, pints	2	$ .79	Medicaid
Peroxide, pints	2	$ .79	Medicaid
Underpads, 25 pkg.	2	$ 5.00	Medicaid
Urinary irrigation set	4	$ 6.26	None
Rubber gloves, nonsteril	1box	$10.00	None
ABD pads, 5"x9"	2 box	$7.65	None
ABD pads, 8"x10"	1 box	$ 7.56	None
Detachohol, 6 oz.	1	$ 6.00	None
SUPPLY (QUARTELY)			
Ted anti-embolism hose	1 pr.	$16.88	None
Hoyer left seat	1	$25.00	Medicare
Wheel chair repairs	average cost	$150.00	Medicare
SUPPLY (YEARLY)			
Action gel pad	1	$85.00	Medicare
Wheel chair batteries	2	$60.00	Medicare
(labor on new batteries)		$30.00	Medicare
Wheel Chair every 5-7 years	1	$5574.70	Medicare in part
		$2183.14	Medicare
		$ 545.78	Blue Cross/Shield
		$2845.78	None

D-2

EXHIBIT D
Page 2

BINSON'S HOSPITAL SUPPLIES, INC.
29634 LAWRENCE • CENTER LINE, MICHIGAN 48015-1881 • (313) 755-2300

BINSON'S PHARMACY
25709 VAN DYKE
CENTER LINE, MICHIGAN 48015
PHONE: 757-2712 — 757-2755

2983 N. WOODWARD
ROYAL OAK, MICHIGAN 48072
PHONE: 398-0440

May 26, 1987

Chanda Hurkett
32915 Ruehle
Warren, MI 48093

List of Medications dispensed since Jan 1, 1987

1. Mandelamine 0.5gm #120 tablets; retail price 21.69 covered by Medicaid
2. Furosemide 40mg #30 tablets; retail price 4.03 covered by Medicaid
3. Bisacodyl Suppositories #24 each; retail price 5.88 not covered by Medicaid
4. Diphenhydramine 25mg #120 capsules; retail price 3.93 not covered by Medicaid
5. Lioresal 20mg #120 tablets; retail price 80.29 covered by Medicaid
6. Lioresal 10mg #120 tablets; retail price 47.39 covered by Medicaid
7. Naprosyn 375mg #60 tablets; retail price 48.49 covered by Medicaid
8. Valium 2mg #240 tablets; retail price 54.79 not covered by Medicaid
9. Cleocin-T 1% solution 30 ml; retail price 10.57 covered by Medicaid
10. Lidex0.05% ointment 60 gram; retail price 29.09 covered by Medicaid
11. Mycostatin Powder 60 grams; retail price 64.09 covered by Medicaid
12. Cinobac 500mg #20 capsules; retail price 27.89 covered by Medicaid
13. Theodur SA 300mg #60 tablets; retail price 15.77 covered by Medicaid
14. Ditropan 5mg #120 tablets; retail price 36.19 covered by Medicaid
15. Macrodantin 100mg #40 capsules; retail price 35.49 covered by Medicaid
16. Trimeth/Sulfa DS (Bactrim DS Generic) #60 tablets; retail price 51.39 covered by Medicaid

These are approximately one month's supply.

EXHIBIT E

SUPPLY	# ALLOWED UNDER MEDICAID	# ALLOWED UNDER MEDICARE
Indwelling catheter	5	2
Catheter insertion tray	5	2
Urinary drainage bag	10	2
Urinary leg bag	10	2

The prices gathered were from Binson's Hospital Supply House. Binson's also supplied me with the information on coverage.

EXHIBIT F

UNIVERSITY OF MICHIGAN MEDICAL CENTER

Department of Physical Medicine and Rehabilitation
University of Michigan Hospitals
University Hospital
1500 East Medical Center Drive
Ann Arbor, Michigan 48109

Theodore M. Cole, M.D.
Chairman

Administration
Electroneuromyography
Occupational Therapy
Orthotics and Prosthetics
Physical Therapy
Physician's Outpatient Clinic
Rehabilitation Engineering
Rehabilitation Psychology and Social Work
Speech-Language Pathology

May 22, 1987

Ms. Chanda Hurkett
32195 Reuhle
Warren, MI 48093

re: Chanda Hurkett
U.H. Reg. #:1707-984-0

Dear Chanda:

Per your request, I would like to review my involvement with you regarding adjustment to your spinal cord injury. I had the opportunity to follow you during your hospitalization here at the University of Michigan Medical Center, Department of Physical Medicine and Rehabilitation in the fall of 1982. At that time, you were admitted to our service for rehabilitation following a repair of a left gluteal pressure ulcer. Numerous other medical problems, typical of spinal cord injury, were also addressed during that hospitalization. I had the opportunity to continue to follow you following this hospitalization for psychotherapy. My records indicate that we continued in outpatient therapy for approximately the next three years. The content of these therapy sessions included dealing with the changes in body image and self concept associated with permanent paralysis, the changes in family and social roles necessitated by chronic physical disability, the need to develop alternative coping resources in the face of lost mobility and severe restrictions in physical abilities, and strategies for dealing with the multiple chronic medical problems associated with permanent spinal cord injury. I think we would both admit that this psychotherapy was extremely helpful in terms of assisting you in greater self-control both in the physical/medical and psychological realms. While it is difficult to speculate, and this may sound self serving, it is my belief that your current and admirable level of psychosocial functioning would not have been possible without this adjunctive psychological support.

Page 2

As we have recently discussed, it is unfortunate that many health insurance policies do not cover the psychological therapies which are critical for the total rehabilitation of the spinal cord injured individual. It is virtually impossible for anyone to sustain a catastrophic illness such as spinal cord injury without undergoing transformations in their self-esteem and self-image, social and family role identification, interpersonal relationships and long term life goals. While the need to address the medical sequelae of spinal cord injury is certainly imperative, for many individuals the associated psychological implications are equally demanding of treatment if the individual is to obtain a long-term prognosis of self care and independence in managing themselves without undue reliance on the health care system. Many of the problems of spinal cord injury are preventable if the individual's psychological status is commensurate with stable mental health. Problems with depression, anger and anxiety can certainly impair an individual's ability to manage their own affairs. As a result, unnecessary medical problems and unneeded and excessive utilization of health care services can be prevented by fostering improved mental health. I would certainly and strongly encourage any changes in legislation which would appreciate the need for psychological services in individuals who suffer from catastrophic illness. I hope that you are successful in your avocation of this need.

It was nice talking to you the other day. I hope that all continues to go well for you.

Sincerely,

Randy Roth

Randy S. Roth, Ph.D.
Clinical Psychologist
Director, Pain Management Program
Department of Physical Medicine & Rehabilitation
Co-Director, Pain Management Clinic
Department of Anesthesiology

RSR/gb

EXHIBIT G

MONTLY EXPENCES
MEDICAL EXPENCES

MEDICATION:	
Bisacodyl Suppositories	$ 5.88
Diphenhydramine	$ 3.93
Valium	$54.79
Ascorbic acid	$ 8.10
Sub total	$72.70
Medicaid co-pay for covered perescriptions	$ 6.50
MONTHLY TOTAL	$79.20

In addition to regul medication, antibiotics have been prescribed for me which were not covered. Example, Noraxin, 20 tablets $49.88, as needed for a urinarytrac infection in February of 1987.

MEDICAL SUPPLIES	
Gauze dressing pads, 8"x10"	$ 7.56
Rubber gloves	$10.00
Urinary irrigation sets (4)	$39.19
Urinary drainage bags (2)	$19.00
Urinary leg bags (2)	$ 8.50
Detacohol, 6 oz.	$ 6.00
ABD pads, 5"x9"	$15.30
MONTHLY TOTAL	$105.55

In addition to monthly medical supplies, some supplies are needed quarterly.

QUARTERLY REQUIRED SUPPLIES	
Ted anti--embolism hose (1 pr.)	$16.88
Hoyer lift slings (1)	$25.00
Wheel Chair repairs (depending on need)	$0.00--$200.00
QUARTERLY TOTAL	$41.88 to $200.00

YEARLY BALANCE SHEET

YEARLY INCOME (Social Security $371.00 x 12)	$4452.00
Monthly medication bill (x 12)	$ 950.00
Monthly medical supply bill (x 12)	$1266.60
Quarterly supply bill (averaged x 12)	$ 600.00
Monthly Blue Cross/Shield Medicare suppliment (x 12)	$ 509.00
YEARLY INCOME MINUS EXPENCES	$1126.00
MONTHLY INCOME MINUS EXPENCES (yearly income/12)	$ 93.00

Senator RIEGLE. Pat Sherman will be followed by George Merreli, will be followed by Virginia Ladd, will be followed by Robert McReavy and then Debbie Roraback, R-o-r-a-b-a-c-k. We'll go in that order. Pat Sherman, George Merreli, Virginia Ladd, Robert McReavy and then Debbie Roraback.

STATEMENT OF PAT SHERMAN

Ms. SHERMAN. Senator, my name is Pat Sherman and I'm from St. Clair Shores. I'm just speaking from a personal point of view.

I have real good friends that a year ago today had to put their mother into a nursing home. I want you to know by April the 1st all of their savings had gone, they are depleted. Hopefully they can get her on Medicaid and I hope they do. But I think that this type of thing has to be resolved.

Personally, I think you're working on it and I think we all appreciate it. I think the nursing home care along with this long term care must be addressed because all of us are going to face this.

And the other thing I want to say is that I am a member of the senior citizens of St. Clair Shores and we have fifteen thousand seniors in St. Clair Shores and most of us are a little concerned about this particular thing. In our center we have about seven hundred fifty members that are all concerned about their health care.

I appreciate the fact that you're really working on it. Thank you.

Senator RIEGLE. Thank you, Pat, it's a pleasure to have you come.

George Merreli.

STATEMENT OF GEORGE MERRELI

Mr. MERRELI. Thank you, Senator, for giving me the opportunity to present to you some thoughts regarding this very serious problem that we've discussed. I think enough evidence has been presented that would indicate the serious need of changes of the Medicare Program. I'm going to speak from experience on two subjects that have not been dealt with but which I feel very deeply about.

My background—first of all, I'm one of those persons fortunately or unfortunate enough to have been involved in the question of health care since 1940. I was involved in the battle to get General Motors to accept the principle of having people pay Blue Cross to be taken from their pay checks so that they could get that health coverage.

I was in the battle of the 1950's of which we were fighting to get national health care in this Nation, our organization UAW was involved. And I was involved in the compromise at that time. I was involved because of my background.

I'm a member of the UAW. I'm retired. This is my tenth anniversary of retirement today. Seems like yesterday.

Senator RIEGLE. I know, doesn't seem possible to me either.

Mr. MERRELI. I pledge myself. Let me give you a little background. I was a representative of the UAW in 1940, became assistant director of a region in 1947 and 1955 was elected director. I handled that position for 24 years until my retirement. So, I was involved in those things.

PRESIDENT NOT SENSITIVE TO ELDERLY'S NEEDS

The question of the long term care, there isn't any question, we need it. But the unfortunate thing about it is, is that the programs that are being submitted. And I want to say first of all that the President's program that was submitted, the only good thing that you can give him credit for is that he finally submitted it to Congress to have something done about it. He deserves no credit or any compassion on behalf of the problems that you've heard about today. His whole history shows that.

[Audience applause.]

And now, a very wrong submission was a prime example of what their real thinking was in regard to this. It was a political maneuver and nothing else. The pressure for health in the catastrophic field did not come about yesterday. It came about 3 years ago back along in the grassroots. That's the politics of this situation.

And I think you as well as your fellow senators and congressmen when you went back home last year, particularly those who were campaigning, heard first hand from the senior citizens throughout this Nation the need for some adjustment in the Medicare program.

So, I don't want, if I sound critical, accept it as a constructive criticism and not as a derogative thing. So, out of that came this move. We need changes this year.

And I hope, Senator, you and your committee can be successful in getting us the long care health that's badly needed, not only in the hospital but the nursing home and convalescent home. The need for in-home care for many proud families attempt to take care of members of their families in this program.

And the tragedy, Senator, I hope that all your colleagues could be here and hear for themselves the tragic event that develops when people are unfortunate enough to have someone with long-term illness.

I have seen not only the spouses of them, but I've seen families be wrecked because of the problem who were proud wanted to take care of them could not do it. And this is the unseen results of the neglected and improper care.

I want to conclude, it's very difficult to conclude my feelings on this question. If I sound like an angry man, I am, on this question because I know many maneuvers by people involved in what I call why should the miseries of elderly people be placed in political football for profiteers and the greedy medical society. [Audience applause.]

That was a hard statement. The unfortunate facts are if the checks were made, you'll see time and time again people are caught stealing from the Medicare fund through manipulation and so forth. Unfortunately when they are caught, the laws do not really give them the kind of justice they should receive because they're taking away money that should be used to help people out that need them.

But no one takes the greed out of the fund. There, I think the Senate House could play a big role. Expand the money, take out and expose those doctors. First of all, those doctors—I don't know if you heard of this, but it's going on now—who had signed up for

Medicare and as I understand it, once they sign and accept the Medicare payments, they are not permitted to charge more than that.

Now, we have this campaign going on. I don't know how spread it is. I just found it out the other day. As President of the Michigan National Council of Senior Citizens, I was speaking up in Roscommon and this came to my attention.

Several doctors in that area are now saying to the patients that previously I would send them the bill with my signature and the check would go directly to the doctor and that's the total payment. They have now said instead of my sending it in with my signature, I will fill it out all necessary papers, send it in, you sign it, send it in. The check comes to you and then you present the money to me after you cash the check.

Well, one case was very interesting. It was a procedure where both Medicare, Medicare coverage I think $270 and he had extra coverage through Blue Cross because he belonged to Pontiac—General Motors, another additional $180. A total of over $400. He received the two checks.

A trusting sole, he cashed them and gave the doctor $440 and the doctor gave him a receipt, a bill for an additional $400 and this is how they're getting around the question of participating. They don't want to participate. They want to be on the list, but they don't want to participate. This is what I call profiteering.

I would like to make the following recommendation without going into too many. We need, of course, home care, nursing care, drug care for the people. We need to be also a, better percentage of the cost of their personal care. I would suggest that you and I, that the program being discussed at the present time particularly your idea and I would have to echo the idea of the present organization, the UAW, that we put it into effect as quickly as we can, with the changes of the following that have been advocated by the Senate, particularly you.

Secondly, this is a political situation, Senator, as you well know. It's not a derogatory remark, but you know the pressure of you people who are elected into public office. And I found that when I was elected also. We do and we act because of the pressure of our constituents.

I think in this situation here you need help, and I want to call upon all of my fellow senior citizens, I don't see most of them here. The lady from Grey Panthers I have been working with said about that petition. That petition was initiated by my organization, the National Council of Senior Citizens in conjunction with many other organizations that are interested in health care.

If we want to get these amendments, then we have to get off of our butt. [Audience applause.]

It's not enough to come here and say what we want. But get these petitions, get them signed no matter where you do it, whether you go to church, club, bar, but get those petitions signed. Those petitions are nation wide and we want to have millions of those placed in the hand, not necessarily Riegle because I think what you're going to do, but if Congressmen and the Republican party and yes, Senator, I'm afraid that I have to say that some of our fellow Democrats needs to hear from the people back home. And

that's what we have to do to help people like Senator Riegle to get this program carried.

And I'm working on this program and I will do every effort to see this program carried out. Thank you very much.

Senator RIEGLE. Thank you.

Virginia, you're next. Before you start let me just say one thing if I may make a personal reflection.

Years ago, George, I remember coming over to visit you when you were Regional Director of the UAW. I was running in a complicated political primary campaign that year. You sort of looked me over to see if I might measure up and so forth and so on. I remember that very fondly, that conversation and our conversations since.

And I just want to say how much I appreciate the individual leadership of people who are out there working to try to make good things happen. [Audience applause.]

The fact that you acknowledged that you just passed your 10th anniversary of your retirement and you're far from retired, you're out there working every single day to try make some good things happen; not just for yourself, not just for your members and former members, but for everybody in this society. That's what this country's about and I really applaud that effort and I thank you for your leadership. It helps inspire me. [Audience applause.]

Virginia, we'll be pleased to hear from you.

STATEMENT OF VIRGINIA LADD

Ms. LADD. I would like to thank you for the opportunity to testify. I will try to be brief because of the time constraint. I probably am going to be a little nervous too so, you'll have to bear with me.

Senator RIEGLE. Don't you be nervous, there's no need to be nervous; you're with friends. I'm not on the stand with you, but I'll help you. So, there's no need to be nervous.

Ms. LADD. I would like to address catastrophic policy based on need and not age. Although I concur with the needs of our elderly and the needs of our senior citizens, catastrophic illness can affect any age. It can devastate any family.

Many patients are red lined out of private insurance; not by choice, they're just red lined out of insurance. They are left uninsured, untreated because they are too young for Medicare and not quite destitute enough for Medicaid and because private insurance has red lined pre-existing conditions, many conditions that people used to be able to be considered fatal conditions are now chronic illnesses. They are catastrophic in their scope in that they last a lifetime. These conditions affect young people.

Lupus is just one of many such catastrophic diseases. I'm a volunteer with the Lupus Foundation and I talk to patients every day that have a tragic story of having to decide whether to put food on the table or spend $40 on one prescription to maintain the control of their illness.

They have no disability insurance. They have no health insurance because they've been red lined out. Even if they are employed, they must make another job choice, if they manage to talk someone into employing them. And many people with chronic illness

can in fact be productive and work, but they have a hard time finding employment. Even if they do find employment, they're red lined out of the insurance.

Many spouses, the whole family is affected because you can't even decide to make a job change to the benefit of your family or to the benefit of society because when you make that job change and your wife has lupus, her pre-existing condition is red lined out of the insurance. So, there you have a family being held down of being able to improve their income and no recourses for them to supplement the care with the person with this catastrophic illness.

That's when divorce starts entering your mind, like the gentleman spoke before. That's not based on age. And I guess this is what the bottom line is. We would like to see legislation or policy based on need.

We've heard many tragic stories here today. The fact that the tragic stories involving people over the age of 65, that's just more evident. However, we could come up with just as many tragic stories that involve people under age 65.

If we based something on age, a policy based on age and not on needs, we will further deplete the funds available to assist people with leukemia, lupus, rheumatoid arthritis, kidney disease, cancers that happen to all fall below the senior level. Again, I'm not taking away from the needs of the seniors, it's just the need out there is so great in these other areas.

For instance, how a society or a government could come up with a regulation that if you applied for disability; let's say you come down with a catastrophic illness, you no longer can work. You apply for disability. It's very difficult to get and only the most bona fide cases are approved. That person must now wait two years for Medicare coverage.

One wonders if the Government does not wish that this person make it. How could somebody with such a catastrophic illness go 2 years without medical coverage of any type?

Need, that's what we're addressing. Thank you.

Senator RIEGLE. Thank you.

Robert McReavy is next, followed by Debbie Roraback, Catherine Knoll will follow and then Raymond Wheaton.

I'm going to ask everybody again to try to be concise as they can be so that we can work on through.

Robert.

STATEMENT OF ROBERT McREAVY, COMMISSIONER, MICHIGAN COMMISSION ON SERVICES TO THE AGING

Mr. MCREAVY. Good afternoon Senator. Before I start, several other Commissioners and some of our staff have been here. Al Rightley the chairman of the commission on service to the aging. Al is over here, you can see him waving. I want to recognize Al. Cathy Needham just left, she couldn't wait any longer. Stuart White, our legislative staff was here earlier. He had to go back to Lansing. So, I will continue.

I might say while I'm talking, that George was wondering where his senior citizens were. George Merreli of the Michigan Council

and I'm a vice president and Al, as I just mentioned, is the treasurer. So, he's not without friends here.

I am Robert McReavy, a commissioner appointed by Governor Blanchard to serve on the Michigan Commission on Services to the Aging. I want to thank you for coming to Warren to listen to your constituents' concerns about Medicare and the economic catastrophes they face as a result of the gaps in Medicare coverage, although gaps in coverage may be putting too kind a light on Medicare's omission.

As you well know, seniors pay a larger percentage of their personal income for out-of-pocket health care expenses than they did before Medicare was implemented. Medicare pays only about 44 percent of a beneficiary's medical bills today.

Prescription drugs used outside the hospital setting, vision and dental care, deductible and co-payments all account for seniors paying more than 16 percent of their personal income for health care today. Seniors who are either sick or poor pay on the average of 25 percent of their incomes for out-of-pocket medical expenses.

These figures do not account for the devastating costs associated with long-term care in a nursing home; care that generally renders the nursing home resident a pauper who is eligible for Medicaid within 13 weeks of admission and a spouse impoverished for life.

Medicare clearly meets an overhaul if it is to provide seniors with the last full measure of protection from the economic hazards of illness. Dr. Bowen's modest beginning in expanding the scope of Medicare's coverage is a welcomed first step, but unfortunately Dr. Bowen's plan will only cure the economic ills of the 800,000 Medicare beneficiaries who currently exhaust their acute care benefits.

As an improvement upon the Bowen proposal for catastrophic health care coverage, the Michigan Commission on Services to the Aging has endorsed in concept House Resolution No. 65, offered by Congressman Claude Pepper.

The Commission believes Medicare should provide its beneficiaries with a comprehensive package of preventive, acute, prescriptive and long-term care benefits. The Pepper Resolution to the crisis in excess to minimal basic care for all seniors represents an idea whose time has come.

Libby Maynard, the Director of the Michigan Office of Services to the Aging, has convened a Medicare reform task force comprised of representatives from the Governor's Human Services Cabinet, business and labor, health care providers, academics, insurers and senior advocates to prepare recommendations for improving Medicare.

The work of this task force is underway. As a member of the task force, I have been asked to inform you that Director Maynard hopes to report on recommendations at your Lansing Hearing on Medicare.

The senior community in Michigan is vitally concerned about the future of the Federal Government's commitment to health care. Again, I am pleased that you are here listening to us and I hope that you will return to Washington with the message that our economic well-being as well as our physical well-being are directly affected by what you choose to do with Medicare.

If I have about half a minute, it was a concern of the Commission on Aging regarding that 3-day stay in the hospital before you could go to Medicare. And I certainly appreciate it and I know the rest of the commissioners will. We need a resolution that contained that problem.

Thank you, Senator.

Senator RIEGLE. You're more than welcome, Robert. Thank you for your leadership and statement today.

Before we call our next person Debbie Roraback up here, I want to give you a suggestion if I may. We've got a Presidential race coming up in the country and we're going to select a new President. President Reagan is finishing his second term and is going to be leaving.

We've got a lot of candidates running in both parties. So, you're going to have a chance here in Michigan to see these candidates. Democrats and Republicans alike will be around knocking on the doors, speaking to groups.

Those of you with very strong feelings about health care issues for seniors and for others ought to make it a point to show up when those candidates come to town and to raise these issues. No one knows now who's going to get nominated or who's going to get elected, but it's very important that everybody that's running have to deal with these issues. And you can help make sure that they do so by showing up at those meetings, and raising those questions.

If you get a chance to speak or if you get a chance to stop one of the Presidential candidates, talk to them about it. And let's see if we can't force this up into a much higher visibility debate issue in the 1988 Presidential Race.

We're seeing right now a very modest step that's been proposed by the Reagan Administration. But if a President decides to really go to work on this issue, if a new President says, "I think we could make changes" in the next few years that would just startle everybody in this room because, as the visibility grows, the chance for doing something substantial on a national basis goes way beyond what we're talking about in this current legislative proposal.

But if the debate doesn't get started, if we don't discuss those issues now, then that next President may not have a commitment to this issue. And we would like to see—those that feel strongly about it—that there is that kind of commitment to improving access to health care, hopefully on the part of both of the candidates that are getting nominated to run for President. But you have a role to play in that. So, I urge you to think about that as an opportunity that's at hand in terms of how we make this political process work for us.

Debbie, let me call you up. You'll be followed by Swarn G. Rajpal, Catherine Knoll, and then Raymond Wheaton.

STATEMENT OF DEBORAH ADAMS RORABACK, NATIONAL MULTIPLE SCLEROSIS SOCIETY

Ms. RORABACK. My name is Debbie Adams Roraback and I'm a health services consumer with a chronic illness, multiple sclerosis. MS is a chronic progressive disease of the central nervous system for which there is no effective treatment. I'm here to give testimo-

ny on the effects of the lack of support coverage for chronically ill persons.

I'm in touch with the needs of the chronically ill through my own first hand experience and through the following activities: Interviewing chronically ill persons for articles I have written for the Free Press attached to my testimony in Conquest Newspaper. Being the founder and program director of MS Peer Support, a telephone support network for persons with MS, and serving on various committees and task forces in the community attempting to find ways to meet the support needs of chronically ill and disabled persons.

Most chronic illnesses like MS have intermittent or long-term catastrophic effects that are not considered. The most seriously devastating being the lack of supportive care. My MS is in remission now. But in 1984, I suffered a relapse of the disease and was seriously weakened by it to the point where I needed help to do just about anything; eating, dressing or bathing.

I struggled with the sudden unpredictable exacerbation of this unpredictable disease with no support except for that what my husband could provide when he was not at his full-time job.

I also had minimal care provided by a health care aide, 1 hour a day, 2 days a week. This was covered by my health insurance only because my doctor had prescribed some skilled care injections of an anti-inflammatory drug, ACTH. The general policy of insurance is that if no skilled care is prescribed, the patient needs no home care assistance. Often that is not the case. On the days that my aide did not come to help, I had no choice but to go without the care that I needed and the personal care that I could not give myself.

The alternative of hiring private non-skilled care is very costly. In this community at least $60 a day more to $10 an hour. And I hear the same thing everyday from people who are chronically ill and disabled. People are constantly struggling to obtain the cost and amount of skilled care they need the attended care, the transportation and the respite care their Care Givers need.

These people require support home care to hold onto their jobs, their families and to make the quality of their lives the best it can be. Because insurance coverage does not exist for non-skilled care, the only alternative is costly hospital acute care for a patient who has a chronic condition and cannot care for his health.

During the 1984 exacerbation of my MS, I spent 1 month in the hospital to receive intravenous medication that could just as easily and more comfortably be administered to me at home at a fraction of the cost of acute hospital care. But I had no choice but to go because acute hospital care is covered by my insurance, while non-skilled care is not covered. Financially the effects of chronic illness is devastating.

To remain in remission, my doctor recommends that I only work part-time and continue to get a lot of rest. The amount of money that I could earn working part-time would not be enough for me to meet my basic living expenses, and I do not qualify for any governmental assistance the way these programs are set up now.

Because of the relapsing remitting nature of the MS I have an insufficient work history record, by only 3 months by the way, to qualify for SSDI, and I am ineligible for the other governmental as-

sistance programs, SSI, because I am not what is considered totally disabled to qualify for that program. So, I like many other chronically ill persons are in a catch-22-type situation where I fall in between the cracks.

All I know is that I worked and paid over $12,000 in the Social Security System. Now, when I need that money I can't get it out. The present system simply doesn't meet the needs of persons with chronic illnesses.

Related to finances, my out-of-pocket expenses due to this disease are overwhelming. Due to permanent vision problems related to MS, I don't drive. So, to get around I rely on inefficient and eroding services of our public transit system and a very costly private transportation system.

The total costs for my prescribed medication per year is about $600. I do not qualify for the State Chore Grant Program which would go a long way towards helping me remain in remission if I could get it.

I also do not qualify for any of the State Utilities Assistance Programs or the Federal Meals on Wheels Program. The latter program would have been valuable to me during the 1984 relapse of my MS.

So, financially speaking if you don't qualify for State or Federal Programs, you drain your savings and go into debt which has been my experience.

Regarding rehabilitation service in the State, I have been frustrated many times when trying to obtain services from both MRS and the Commission for the Blind. From my experience, the level of service given seems to vary from client to client because rehab workers are given so much control over each case. In the present system, each State is given the power to distribute Federal Rehab Money and regulate themselves and really aren't held accountable to anybody.

In some, the lack of non-skill support home care coverage, support services, and governmental financial assistance forces persons with chronic illnesses into more dependent and sometimes destitute level of existence. I could be more independent and productive in society if coverage and support services existed to meet needs.

Some solutions that I see to meet the needs and bridge the gaps are one, health insurance coverage for non-skill care for chronic conditions. Build into the system enough flexibility so that no matter what the condition is, an individual can get their needs met across the board whether a condition requires short-term care, or acute, or intermittent care, or long-term maintenance care. Also provision coverage for support services such as transportation, respite care, chore services, et cetera.

Two, reform and extend benefits of financial assistance programs; such as, SSDI and SSI, the Meals on Wheels Program, State Utiiities Assistance Program, and Chore Grant Program to meet the needs of the chronically ill population.

Three, placement of more support of the Care Services in the community; such as, reforming the present public transit system to be more accessible and provide more comprehensive services to meet needs of the chronically ill.

And four, reform the present rehabilitative services system or adopt an alternative plan such as the one proposed by the National Federation of the Blind called the Prechoice Plan. A description and fact sheet are attached to my testimony. The plan is a cost effective approach which would allow clients greater selection of relevant services not limited to those available through assistance by a single agency in each State, which is what's going on now.

And I thank Senator Riegle for the opportunity to speak at this hearing.

Senator RIEGLE. Debbie, before you leave, I just want to tell you how powerful your statement is in your own example. I can't thank you enough for coming today and waiting for your opportunity to speak and for speaking.

I have heard a lot of testimony and in 21 years in the Congress I don't think I've ever heard any more testimony that was better prepared and more to the point than yours. And I think it says something about your ability to focus an issue and to lay it out there despite these problems that you're coping with.

So, I just want to thank you and tell you that we're going to see what we can do to try to help you.

[The following was supplied for the record by Miss Roraback:]

[From the Detroit Free Press, May 10, 1987]

HOME CARE OFTEN DOESN'T EXIST FOR THE CHRONICALLY ILL

[*Deborah Adams Roraback is a Dearborn woman who lives with MS. She has been actively involved with the Multiple Sclerosis Society's Peer Support Line and has worked with the Chronic Illness Awareness Coalition an organization of agencies concerned with issues such as housing, transportation, insurance and attendant care for people with chronic illnesses.*

In this two-part guest column, which will conclude next week, Roraback discusses an issue she and I have talked about often—home health care.]

(By Deborah Adams Roraback)

We try to forget the bad times. Until now, I've resisted writing about my own experience with the lack of supportive home care partly because I didn't want to remember those days during the long winter of 1984 when I was having my worst exacerbation of MS. It seemed then as if it would never get better.

I did get better. If took about five months, to come to a reasonable state of remission, except for more and permanent optic nerve damage to my already impaired vision.

But by then, I have acquired a cynical attitude toward the health care profession and the health insurance industry which, at times, seems to say to the chronically ill population: "If we can't cure you, then providing you with the care to meet your varied needs is not on our list of priorities."

This attitude doesn't make sense. Curing and caring must go together in treating the chronically ill, and that should be health care's focus—to promote an individual's maximum health and abilities.

Because of a lack of supportive home care during the first three months of 1984, my own quality of life took a real nosedive.

No immediate family members or friends were able to help me during my health crisis because most had their own families to look after. Even those capable of helping seemed to want to separate themselves from what was going on with me; they chose to stay away.

I struggled with the sudden, unpredictable exacerbation of this unpredictable disease with no support except for that my husband could provide when he was not at his full-time job. I also have minimal care provided by a home health aide one hour a day, two days a week. This was covered by my health insurance only because my

doctor had prescribed some skilled care (injections of the anti-inflammatory drug ACTH). The general policy of insurers is that if no skilled care is prescribed, the patient needs no home health care assistance. Often, that is not the case.

Seriously weakened by the MS, I needed help to do just about everything--eating, bathing, dressing. On the days my aide came, I knew I would be eating, I knew the commode next to my bed would get emptied, and I knew and looked forward to the companionship of another human being. The other weekdays my husband left food for me, but most of the time I was physically unable to feed myself. Sometimes he'd rush home on his lunch hour to feed me, but that routine began to harm his own health. We couldn't risk that because he was providing our livelihood.

When we tried to find alternatives, we were amazed at how frustrating it was to find agencies or people who seemed to know what was available regarding home care help. We were also surprised and disheartened to find that the sparse resources that did exist were too expensive for us.

Others have been equally amazed and frustrated. Janet Glasberg is president of the ALS of Michigan. ALS, also known as Lou Gehrig's disease, is a progressive, paralytic disease of the motor nerve cells, the cause of which is unknown and for which there is no treatment.

She says she feels "frustrated and helpless because I cannot hook up my ALS patients with the home care help they desperately need because those resources just do not exist.

"Right now, I have two ALS patients who can't even get themselves out of bed in the morning because their arms are paralyzed and I have been trying without any success to get them the care that they need," she said. "It seems that the bottom line is if you have a chronic disease where you aren't expected to get better, no one seems willing to help you."

After I failed to find the care I needed, I encountered what I call the missionary attitude. If a person can't afford the going rate for non-skilled home health care which in this community is at least $60 a day or $8 to $10 an hour, you are at the mercy of the missionaries, the churches who can hook you up with volunteers.

I was lucky. After a few weeks, a church near my home contacted a charitable neighbor of mine who volunteered to help me on days my aide did not come. She cooked, bathed me, took care of me, read to me. I'm convinced her positive attitude, sharing, and caring started me on the road to wellness again. I was extremely lucky to have found this woman.

But what do you do when there are no missionaries around? You go without. I hear about this every day from people who are chronically ill and disabled, people who are constantly struggling to obtain the costly non-skilled care they need—the attendant, the transportation, the respite care their care givers need. These people require supportive home care to hold onto their jobs and their families and to make the quality of their lives the best it can be.

More often than not, the community does not have the resources to meet these needs. People often become frustrated and depressed, and some even give up and stop their search.

Are the churches responsible to bridge the gap and meet the unmet needs I've described? Or do all people share the social responsibility to help those in need?

Next Week: efforts to bridge the gap.

[From the Detroit Free Press, May 17, 1987]

Handicappers Get Into a Business They Know a Lot About

[In the second of her two-part guest column, Roraback continues her discussion of home health care.]

(By Deborah Adams Roraback)

People who need affordable home health care—who are chronically ill and disabled, who need non-skilled care for attendants, for transportation—often have trouble finding it.

The state-funded chore grant program pays for homemaker services for people who qualify medically and financially. This program may offer some help for people on fixed or low incomes, but the middle-income group is left out in the cold.

"I could pay someone to come in and help me out. But it would quickly fritter away what little savings I do have, and I need that money to pay for other medical expenses that my health insurance company does not cover," said a 30-year-old woman with MS who has two young, active children.

Her doctor recommends she get "lots of rest" because of her medical condition. However, without outside help, she doesn't get rest and must struggle to care for her family and herself.

Out of personal experience and frustration, one East Lansing woman found an innovative way to get the home care services she needs. A quadriplegic who uses a motorized wheelchair, she requires some home care services to maintain her independent life-style.

"Agencies sent out aides who had less experience than people I could obtain myself to work for me on my own at a much less expensive hourly rate," she said. "The home health aide help provided was not flexible enough to meet my needs. It did not mesh with the kind of schedule I keep as an active handicapper employed full-time."

Two years ago, she began operating a personal care company, which now has 10 clients. Because her health insurance company rejected billings she submitted to them for hiring her own non-skilled care help, she decided to see what would happen if she created a personal care company of her own, and then submitted billings through her own company. They were paid. (Note: This strategy won't work in every part of the state with every private insurance company.—Jim Neubacher.)

The services the attendants employed by her company provide include doing light housework, bathing, dressing and transporting clients. These cost about half as much as the home health care aide services that her health insurance company had been paying for, and the services are geared more toward maintaining the life-styles of active handicappers, she believes.

Handicappers in her firm are actively involved in managing their personal care assistance services, which results in flexible, quality services at reasonable rates with maximum respect for the customer's independence. This illustrates the need for comprehensive, supportive non-skilled care that is flexible enough to mesh with the life-styles of handicappers.

Some people in the community and at the state and legislative level are beginning to take a serious look at this long-neglected issue. The Coalition on Access to Health Care, spawned by the Michigan Protection and Advocacy Service, is a newly formed group of individuals interested in securing adequate health care.

The coalition first met in February and is planning a statewide conference for this fall in Lansing. Among the individuals involved in this planning are representatives from the hospital industry, the health insurance industry, and state government.

Another group looking into moving more supportive care services into the community is named HANDSOM, for Housing Alternatives; Needed Directions for Services, Options and Management. HANDSOM has drafted a position paper and presented it to C Patrick Babcock, director of the Michigan Department of Social Services.

In Minnesota, the Home Care Advocacy Program is a model in home care and organizers hope to help groups in other states organize similar programs. It provides direct service and referral for the severely disabled with a goal of helping them remain in their own homes.

One of the founders is Susan Margoles, a patient care advocate who has ALS, a progressive, paralytic disease of the motor nerve cells, the cause of which is unknown and for which there is no treatment. Margoles organized the 24-hour home care she needed to live at home rather than be in an institution or nursing home.

The Minnesota Home Care Advocacy Program has advocates working nationally on the home care issue and will sponsor a national home care conference next month in Minnesota.

One of the speakers at the conference, to be held in conjunction with the University of Minnesota School of Nursing, is author Norman Cousins, who is also on the Minnesota Home Care Advocacy Program Advisory Board. For more information about the conference, call (612) 627-0101.

The public benefits from the provision of supporting home care. Inadequate care deprives society of its most valuable resource—human beings. Failure to provide good supportive care leads to lost human potential.

[Fact Sheet]

Breaking the Monopoly: A Free Choice Plan for Training and Employment of the Blind

OUR GOAL: FREEDOM TO LEARN

Background

In 1920 Congress created the Vocational Rehabilitation Program for the purpose of providing job skills and employment to handicapped people who could work despite their impairments. The term "vocational" was deliberately used to identify the employment-centered nature of the program's goal.

In more recent times, however, the term "vocational" has been dropped from the name of the law altogether. With that change and other substantive amendments to the original, basic legislation the goal of employment for the handicapped is becoming ever more obscured.

The modern-day rehabilitation act (known as the Rehabilitation Act of 1973, as amended) authorizes and supports a constellation of medical, social, recreational, vocational, educational, and research oriented programs and other efforts that are intended to improve the living conditions and life styles of all disabled persons in America. Employment is now one of many objectives of the law, and certainly no longer the principal one.

Yet, lack of good training and employment opportunities remain the uppermost priority need to be fulfilled for more than 70% of all blind people from the time of high school graduation to retirement age. Recreation, social services, and even medical care needs will almost all be met for the vast majority of these blind people if they get suitable jobs with pay and responsibilities commensurate with their individual abilities.

Existing Law

Current programs (supported with almost 1.3 billion dollars in federal financial assistance) are operated largely on a single state agency concept. The blind person in need of training and employment assistance must seek help from a specific state government agency designated by law to receive the federal government's blessing and funds to provide rehabilitation services.

The state agencies thus control the money (and in many respect the lives) of those blind people who are trying to become self-supporting and free from government assistance. Options for choosing the agencies from which to seek training and employment assistance are realistically nonexistent for most blind people. Lack of a free choice for each blind person to obtain needed services from a public or private agency, selected by the individual (not by the government), is a major deterrent to effective, responsive training and employment assistance. Blind people who need help to get jobs are interested in results, not in programs.

Description of the Free Choice Plan

The free choice plan for training and employment services can operate in tandem with the present federally assisted state agency structure already in place under the Rehabilitation Act of 1973. Under a 1981 change in the Social Security Act, funds from the Social Security Disability Insurance (SSDI) trust fund and appropriations for Supplemental Security Income (SSI) are paid to the state rehabilitation agencies whenever an SSDI or SSI recipient achieves successful work as a result of a rehabilitation program. But since results (successful work) are essential under the law for a state agency to obtain reimbursement from the SSDI or SSI funds, most of the state agencies participate only to a small extent in the rehabilitation program authorizing the distribution of Social Security funds when successful work is achieved.

A natural alternative to the present Social Security funding arrangement would be to allow recipients of SSDI or SSI benefits to designate for themselves individually selected sponsoring agencies, public or private. These individually chosen sponsoring agencies could provide services directly or help to obtain services from other programs. This approach (funding the participants and letting them choose their programs) would give each person a wider selection of relevant training and employment services. Since most blind people who are not employed receive either SSDI or SSI cash benefits, they would be immediately eligible to obtain the training and job related assistance they need through the free choice plan. They could continue with a rehabilitation program under the existing state agency structure; or, with the help of a sponsoring agency of their choosing, they could obtain alternative training and employment services through any other program they select. In either case SSDI or

SSI funds would eventually pay the bill as is now done through state rehabilitation agencies only. The cost to the Social Security funds would not be increased.

Advantages of the Free Choice Plan

The free choice plan would be a natural adjunct to the existing state rehabilitation agency structure. It would leave the existing programs intact with all of their present financial support now provided under the Rehabilitation Act. The difference would be greater selection of relevant services not limited to those available through assistance by a single agency in each state. State boundaries (and limits on out-of-state expenditures) would not prevent finding the best program for each individual. Under the free choice plan a source of funding (not tied to any state or any agency) would be available for anyone who wanted to exercise a free choice.

To the extent that such a program would stimulate competition among agencies to make their philosophies and programs attractive to potential participants, the free choice plan would create a healthy new environment of services full of new opportunities and growth. In addition, Social Security funds paid to achieve training and employment goals would reduce demands for continuing cash outlays from the SSDI and SSI programs. This is a cost-effective approach that Congress should now enact.

Senator RIEGLE. Swarn, let's have you and then Catherine Knoll and then Raymond Wheaton, and then Randy Block will follow. Let me tell you how we're going to have to proceed.

We're going to continue the hearing until everybody that wants to speak for the record has a chance to do so. We're also inserting a number of statements in the record that people have given us in writing and they will also be part of the record. And anybody else that wants to do so is invited to do so.

I am going to have to excuse myself because I have to return to Washington today by plane and I'm going to have to leave in about 15 or 20 minutes.

When I do, I'm going to ask David Krawitz who's seated here beside me and who's serving as legislative assistant along with Joan Huffer on this side of me to assume this Chair and to proceed as we take the rest of the public statements one by one as we go down through them.

And we will remain here in an official session with the stenographer building this public record until everyone who wishes to speak has a chance to do so. So, that will be the procedure that we follow and we'll go next to you, Mr. Rajpal.

STATEMENT OF DR. SWARN G. RAJPAL, PRESIDENT, INDIA LEAGUE OF AMERICA OF MICHIGAN

Dr. RAJPAL. Thank you, Senator Riegle. I am Dr. Swarn Rajpal, President of India League of America of Michigan and a practicing general surgeon. I feel greatly honored at being given the opportunity to express my views on this crucial subject of catastrophic and long-term health care.

The issue affects not only elderly people, but people of all age groups. Unfortunately, the Bills of the Congress at this time do not really address the heart of the matter which is how to pay for the expenses of sick and disabled people once their acuteness is over. I will try to illustrate this point with an example or two.

The first one is the story of an 80-year-old lady of whose care I was personally involved. This lady was legally blind due to diabetes. Last summer she fell at home and broke her hip for which she had to undergo an operation. Unfortunately, after the operation

she developed complications and became unable to walk and feed herself or even turn in bed.

She had Medicare and a supplemental health insurance which covered her expenses during her acute care in the hospital. This kind of coverage is essentially what the proposed bills on catastrophic and long-term illness are commending. Eventually after many months in the hospital, she no longer qualified for acute care and the family was advised of this. Now the family had the catastrophe.

The patient had to be discharged from the hospital. She had to either be taken home or admitted to a nursing home. She required continued nursing care, the cost which had to be borne by the family which it could ill-afford.

The family was very reluctant to take this lady out of the hospital setting. It took another few months before a suitable place for this lady could be found outside the hospital. Of course the family remains responsible for all the bills.

The second example comes from a member of our community who was the sole bread winner for two small children. He was a hard worker and had made a comfortable home for himself and his family. As fortune would have it, a short illness left him comatose in the prime of his life and the family devoid of any income was left to pay his bills.

The health insurance covered for in hospital care during the acute phase, but once he was discharged from the hospital the problem became compounded. The allotted governmental assistance programs for this tragic situation, the family has to spend down to a certain poverty level to be eligible for such assistance. So far, the family hasn't elicited any offers of charity to maintain self-esteem and avoid humiliation.

This person when fully employed contributed his fair share towards taxes and Social Security. Once he has become an invalid, the government policy does not distinguish him from someone who has been on welfare all along and never contributed towards the Government revenues. This seems to be a highly unfair situation and the family continues to struggle into the second year of disaster at home.

Briefly, I would like to address the issue of children born with birth defects. The current health insurance program and medical technology is able to keep 1 pound and 2 pound babies alive and be discharged from the hospital many months later. These children many times physically, mentally, or emotionally are impaired. Providing care for them at home or in an institution is expensive. Only if the family can qualify for Medicaid or Premature Children Programs is there any relief. Otherwise the family has a real catastrophe on its hands.

The matters, of course, are a lot more complex and have to be sorted out with regard to its moral and ethical implications along with what should be the Government's role in all of this.

In passing, I would like to mention a unique health care problem that our community faces in this country. Since we are a relatively young community of aging here, our elders are still back home in India. They're having more than a few instances where parents vis-

iting here have been stricken with illnesses requiring prolonged and expensive care.

This has proven to be a financial heavy burden on the whole family. The India League urges you to kindly consider the matter of providing families with health insurance at a reasonable premium which unfortunately is not available commercially.

In conclusion, I feel the bills addressing the issue of catastrophic and long-term illness now being debated in the Congress, although steps in the right direction in providing comprehensive hospital care for the catastrophically ill fall far short of providing extended health and nursing care. Unfortunately, it is the latter which is a source of strain on the family's final resources, health, and welfare.

Thank you.

Senator RIEGLE. Thank you very much. I think those are excellent comments and I just want to say that we appreciate your comments and your representation of the India League of America. I want to note in passing that there are many skilled Asian-Indian American physicians, who make a tremendous contribution to meeting the health care needs in our country. I've seen that with my own family.

But I just want to acknowledge that great contribution and thank you for your testimony today.

Catherine Knoll, is Catherine Knoll here?

[No response.]

Perhaps she may have left.

Raymond Wheaton, is he still here? I don't see him.

[No response.]

Randy Black, is he still present? Ruth Black, is Ruth Black here?

[No response.]

Catherine Needum we've heard from. Have we not?

The AUDIENCE. She left.

Senator RIEGLE. Charles Dewey, William Diemond; Diemond is it?

Mr. DIEMOND. Either.

Senator RIEGLE. You'll be followed by Susan Kirk; is she here?

[No response.]

Marty Mazurko, Marty you'll be following next.

Stephanie Churilla, C-h-u-r-i-l-l-a; is Stephanie here?

[No response.]

Esther Callahan, Catherine Doskocz, D-o-s-k-o-c-z; is she here?

[No response.]

Marguerite Kane, you'll be third here in this order.

Mr. Diemond, we would be pleased to hear from you now.

STATEMENT OF WILLIAM DIEMOND

Mr. DIEMOND. Thank you very much for this opportunity to speak to you today. It's something long past due. In trying to bring it down to 3 minutes, I want to show how a senior citizen improves in intelligence over the years instead of reduces and is able to say 5 hour stuff in 3 minutes.

Senator RIEGLE. Good. I want to hear this because I'm counting on that happening to me as I get older. I'm going to get smarter.

Mr. DIEMOND. You are, I say this not out of flattery, you are. You're not more intelligent, but you're getting wiser every year.

Senator RIEGLE. Thank you.

Mr. DIEMOND. In reducing it, I want to say conclusions where I don't state a fact. One is Congress is running behind on this issue. You aren't in front of it and you better watch out. It could have the overwhelming snowball effect. The current administration, I think, is not only too little too late, but is off the mark. I'm reserving my view on the Supreme Court.

The one thing I want to say clearly is that this not reduce itself into a senior citizen-junior citizen argument. That is ugly, it is inappropriate and it is highly inaccurate.

For example, I and 18 others provide through phoresis process with the American Red Cross, blood or parts of blood to a little 4-year-old fighting for his life out in Ann Arbor as part of the bone marrow transplant program. [Audience applause.]

None of this is self-serving, please believe me. The interesting thing is that I came in at 65 to offer giving blood by phoresis. They turned me down at first.

I argued my way in and now they won't let go of me because by some peculiar match of my blood and the little fellow out there in University Hospital who has to have a transfusion every 2 to 2½ days, when he gets mine and one other person out of there, we seem to have the match and it's helping him kick in that much better. So, it is not a senior-junior sort of thing.

The other point that I want to make quickly is that I bought an Omaha Mutual policy for catastrophe insurance in about 1955 and it continues this day for $10, $10. You have to say dollars because it would be $60 a year now. This is how distorted, how far this problem has expanded, worsened and everything because $60 won't do it today.

The other point I want to make as a fact, is that there is an acute nursing shortage in the Detroit area right now. The only two big demands today in Detroit really are for nurses and fast food persons.

The other thing that I think you should inquire about and I don't want to make a flat statement on it, is that Medicare Plus which is sponsored by Blue Cross has now withdrawn its basic option which used to be for $10 a month and you got the additional hospitalization. They've increased it to I understand $36.50 a month and they have now discontinued their option up for eyeglasses, for one other—oh, prescriptions.

Now, when I say the word prescription, over at our senior center I fill out tax returns for senior citizens. Last year I had the very peculiar thing happen of two persons' tax returns being filled out and the persons each had paid in excess of $600 in prescriptions on incomes in the neighborhood of $7 or $8 thousand and the odd part of it was had they gotten a Medicare supplement, they would have the included prescriptions. They would have had enough money to pay for not only their Medicare, but the Medicare supplement. So, information is not effectively getting down, although there are some marvelous efforts going on in Macomb County.

I speak for no further away than the Macomb County and the various senior citizens centers that are growing here in the county

are doing a terrific job. There's one here in Warren, Sterling Heights, St. Clare Shores, Mount Clemens. They're growing and serving much better and should be worked through in anything trying to get these people knowledgeable and involved because you have people who are not coming into the center who are dying on the vine literally.

Another thing that I want to urge is that anything that could be done at all to make use of senior citizen's free time. There are two things that we have. One is more free time than the average citizen.

Now, I've been to two luncheons in the last week or so and the range of number of hours given has been quite great. And unfortunately, it has been overwhelmingly women. There has been a real absence of men, but they could do some of these chores that are going to increase this cost. Multiplying the number of hours by senior citizens in a regional participation, you should be able to pull out somewhere in the neighborhood of $10 to $20 million a year in free service without impinging on union or anybody's income or anything like that.

I feel very strongly about a couple of things. One is cutting out the fraud that has appeared in the hospital programs and in the Medicare Medicaid Program. And the other is and I think this should be struck head on, is a certain amount of arrogance that is in the medical profession that is making people be untreated properly.

Some instances, there's a woman from Warren here who had two children. She lost both of them to cancer. Both of them through the same doctor and the reason apparent reason that it was lost is that the doctor would not spend the money for the tests that were necessary; saying that it was too expensive. She lost the two children.

Another thing——

Senator RIEGLE. I don't want to cut you off——

Mr. DIEMOND. I got one more strong point and this is the one of who this affects. There are all kinds of figures banding about how much income senior citizens have.

After filling out tax returns and watching newspapers, magazines and so on, I see it ranging per household somewhere in the neighborhood of $6 to $12 thousand a year. If you will take that and apply to it the necessities, no, luxuries you're going to find the people coming down to the wire with very little to the point where $4 a month even is going to mean an awful lot. If they're going to save that or certain income brackets, they should be saved.

And the other thing that I want to point out, I learned this in debating in high school up in Alpena; as long as you keep your sentence open——

Senator RIEGLE. All one hundred Senators know that trick.

Mr. DIEMOND. There have been two excellent programs by ABC that should be shown to everyone that will just plain look at them. One is Growing Old in America which was done about a year ago, close to a 3 hour program. It's an excellent program for treating part of the problems you're talking about here.

And another one which was Friday night and again, this one is a, to me, a critical one. It had to do with the biological effects of alcoholism and drugism and some of the things that are drifting

into our age group are an accumulative sort of thing and that has to be hit head on.

One other thing, there have been twenty-three hundred American diets written since I was born. Now, that absolutely makes no sense at all. There should be the Department of Agriculture or somebody should do a careful, capable summary of what is a suitable diet and then we start from there all over again and the build up 2,300 in another 67 years.

Thank you very much.

Senator RIEGLE. William, thank you. I'll tell you this, you said a lot in a short period of time and you're a great advertisement for the Alpena High School Debating System too.

I'm going to have to make a couple of summary comments myself because I've got to go back today actually to work on this legislation in Washington. So, I've got a plane scheduled to leave. I want to acknowledge again, we're going to go right on through and take everybody else's testimony for the actual record and Mr. Krawitz is going to officiate during that period.

I want to say that when we started out here this morning, we had over seven hundred people in the room and every single chair was filled. I think that's a remarkable showing of interest by yourselves and the others that have been here on these issues. I think it's a remarkable showing about the fact that government, self-government will work if we just give it a chance.

We have an opportunity for meetings like this, and settings like this where we can have an exchange of views and we can accumulate the insight that resides among our citizens. If we just collect the facts in an orderly way and get them on the public record, and then take those facts back and work hard in the legislative process as we should, we can develop strategy and approaches for solving these problems.

If any of you who would like to get detailed information on these health care proposals as they're being developed and refined and voted on and so forth, leave your name and your address before you leave today with the staff so we've got a way to mail you information on an ongoing basis.

I think the point has been well made today that the health problems don't begin and end at age 65 or age 62. I thought we saw some very touching and powerful examples of younger people here today who are experiencing at an early age what our seniors are experiencing at a later age. I think as society we want to be responsive to the needs of everybody up and down that ladder.

We don't want to make a differentiation on discrimination to say, well, you've got a terrible problem, but, we can't respond to yours, but this person over here of a different age, well, we'll respond to that. I think as a society we ought to step up to meeting those responsibilities for all of our citizens by devising a system that could work on that kind of a broad base.

I'm very honored by the fact that you came out here today. I'm personally appreciative of the fact that you've been here. It's important for me to get this collected wisdom inside my own mind and inside my understanding. And for you to come today and to take the time and particularly those of you who have waited so

long to speak and become a part of this record, I'm very grateful to you and it's very important that you do this.

I want you to know that I understand the importance of your statements and the value of this information for the work that I try to carry out on your behalf, in our name as a state. You can be sure that I will do everything that is humanly possible in working on this health care legislation to try to make it the right kind of legislation, so that it is fair; so that it is as comprehensive as we can make it; so that it actually reaches the people.

And if we can only get part of it done now, we'll get that part done, but I'm not going to rest at that point. I'm going to then be working on the next part, and the next part, and the next part and as many parts as it takes until we have all the parts done because I think that's what our goal has to be and I can tell you that's what my goal is.

So, I want to thank you for coming. I wish I could stay, but I will read everything that is said and the hearing will continue in its official capacity until every person here who wishes to speak has spoken.

So, with that, let me ask Marty Mazurko, who is next, to come up and take the microphone. I'm going to ask Mr. Krawitz to take my seat and I'm going to excuse myself and again, thank you.

STATEMENT OF MARTY MAZURKO

Mr. MAZURKO. If you could stay there 2 minutes, Senator Riegle, I sure would appreciate it. My remarks will be very short. I'm not against anything that helps people. Meaning that I'm not against the catastrophic plan, but I'm for a National Health Plan. That will cover everything and that will solve all our problems.

This year we celebrated the two hundredth birthday of one of the greatest nations that ever came to be on this earth. Two years from now we're going to celebrate the incorporation of the Bill of Rights into the Constitution of this great Nation.

And I'm only going to say to you, Senator, take this message back to your colleagues: Wouldn't it be a beautiful gesture that if the Congressmen and the Senators of the United States of America would bestow on all of the citizens in this country a national health plan as one of the greatest birthdays you could give us, the American people, so we can live a much better life. [Audience applause.]

I sure would appreciate it if you said that to the Congress, to the Senators.

Thank you very much.

Senator RIEGLE. Thank you.

Mr. KRAWITZ. Marguerite Kane.

STATEMENT OF MARGUERITE KANE, DIRECTOR, SENIOR CITIZENS PROGRAM, CITY OF ROYAL OAK, MI

Ms. KANE. I have my testimony here that you can enter into the legislative record. I also have a film, a video that I would like Senator Riegle to take back with him to Washington so that they can see for themselves some of the people that are helped directly by the local community center.

I'm the Director of the Senior Citizen Program in the City of Royal Oak which has over seventeen thousand elderly. We're supported by Community Development Block Grant Funds. Although I could use statistics and everything else, I don't choose to. I would like to have them review this film. It's called the Invisible Elderly and it visits five of the people our program helps. I thought if they saw this in person it would make much more of an impact.

Thank you, very much.

Mr. KRAWITZ. I'll be sure the Senator sees that, thank you.

[The prepared statement of Miss Kane follows:]

PREPARED STATEMENT OF MARGUERITE KANE

Senator Riegle, members of the audience, my name is Marguerite Kane and I am the Senior Citizen Coordinator for the City of Royal Oak which is home to over 17,000 persons over the age of 60 with over 4,000 persons over 75 years of age. Today, instead of telling you horror stories about the health care system and Medicare DRG's, I am going to tell you what our community is doing with a little help from the Federal government to help alleviate the tremendous impact that is occurring because of inadequacies in the system.

We realized in Royal Oak that the DRG's were creating a heavy burden as calls flooded our Senior Community Center for affordable in-home care following surgery or illness, or asking respite for caregivers of terminal or catastrophically ill family members, or for transportation to hospitals for out-patient therapy; sometimes, several times a week over a period of months.

You may not know that many seniors purchased HMO plans for hospitals miles from where they live and no transportation is provided by these organizations. You might also be interested to know that few hospitals provide any transportation for the thousands of seniors who are now being treated as out-patients instead of being admitted to the hospital. The local Senior Center must assume the responsibility to transport these persons who need personal escort.

With a small grant of $6,238 from the Area Agency 1-B we built a volunteer program that provided over 8,000 hours of home aide, to seniors discharged under DRG's, respite service, and frail elderly escort during its first year, all at no charge to our elderly and their families. This is less than it cost to keep a person in a nursing home for 3 months and much more humane. The program is now funded by a grant from Beaumont Hospital in the amount of $8,500 and by October 1st will have exceeded 24,000 hours of free service to the elderly; all of this with very little money and a lot of effort by the local community.

Our Center also provides other services; Outreach, Home Chore, Home Repair, a Postal Alert, Crisis Counseling, and a Hot Meal Program. All of these services are dpendent on support by the Federal government; in particular, Community Development Block Grant funds. Many small communities such as ours depend upon C.B.G. funds to provide these services to the elderly. I cannot emphasize too strongly that without Block Grant funds, the Royal Oak elderly would have no senior center and no supportive services.

I could have quoted statistics today to try and prove my point. I have them; numbers of people served, numbers of units of service; but, when you are a service provider at the local level, numbers do not adequately portray the individual in crisis. Numbers don't help you hear the desperation of an 80-year old woman who has been sent home from the hospital in pain, bedridden, not qualified for skilled care, on a $5,000 income a year, no available family, and who is on a waiting list for homebound meals. She is not sick enough for a hospital and cannot afford private care, does she lie at home untended until she dies or do we find a way to provide basic in supportive services for her?

Numbers cannot portray this situation, so today I brought with me a video for you to take back to Washington, Senator Riegle. It's called "The Invisible Elderly" and in it we visit the homes of five older persons in Royal Oak. It has been shortened so that it gives you just a glimpse of some of the real people our Center provides service for. One is blind and alone, one has experienced a traumatic DRG, one has full care of her terminally ill husband. Tell your constituents that we are doing a job out here at the local level; but, we need their continued and increased support.

Thank you.

Mr. KRAWITZ. Is Mary Casuna here?

[No response.]

I have a whole bunch of people. Maybe we could just start at the front and if people who want to testify, why don't you just come down and line up in this front row here and we'll take you in order, starting there, please.

Could you state your name?

STATEMENT OF KENNETH GIBNER, VICE PRESIDENT, RECORDING SECRETARY OF THE COUNCIL, UAW REGION I, LOCAL 140

Mr. GIBNER. My name is Kenneth Gibner and I come out of UAW Region I and UAW Local 140. I'm vice chairman and recording secretary of the council. I want to thank you for giving me the opportunity to come here and speak. There's a lot of things and a lot of cases that I could refer to because I work in helping people in the Medicare and Blue Cross.

I'm fortunate that I come out of Chrysler's which gives me a little better health care than the majority of the people that were here today, the seniors that were here today.

What bothers me the most is the fact that there are some people in our, in my own local that are in nursing homes where the husband or the wife happens to be in the nursing home. I want to relate one case because it's very important to understand what happens to a senior once the spouse goes into a nursing home.

In this case, the senior is 86 years old. His wife is 83. She was in the nursing home to where all funds were gone, but making enough money to where Medicaid would not pick up the cost of the Medicare coverage or to cover her in the nursing home. So, what has happened, he has to bring her on home. When he brings her on home, he has to—now, he only weighs 130 pounds. His wife is 150 pounds. So, he can't lift her. She had a stroke by the way and is in very bad shape.

So, he has to now hire someone to come in everyday at $160 a week is what he pays out of his pension to take care of his wife. Plus the fact that medication—now, she has to be taken to the doctor every 60 days.

Now, how do we get her to a doctor when we don't have a—he doesn't drive. There's nobody to take her. So, we have to call an ambulance. So the ambulance—the doctor's office is only 3 blocks away—$100 the ambulance wants to take her there and bring her back.

So, what happens we actually get the ambulance company to do it for $50, $25 each way. This is the type of thing—in another case in a nursing home, $40,000 has been paid out, funds just wiped out completely.

There are people out of my own local chapter that have health care that is basically 100 percent better than 90 percent of the people in this country. So, when you start looking at this type of situation in the national health and why we need national health.

I have a couple of cases here and I know there's a lot of people that want to talk too. And I know you want to get through with your day, but I have a case here, $124 thousand paid out and he's told he's got to pay $3 thousand that he might owe. Another case where an individual is going into the hospital for therapy. All of a

sudden Blue Cross and Medicare says that this is not a covered benefit. So, now he owes close to $3,000 and the hospital will not take him anymore because they say this coverage is not there for him.

I looked up and see the drug percent on the chart there and it says 1 percent. I go into a drug store and order my prescription and I put down $4 and a senior in front of me getting a prescription for his wife that does not have the coverage. And for that same pill that I paid $4, he put out $55 to pay for that prescription.

Those are the types of things that have to be taken care of in our health care coverage. And it's important that we even look into the new law, the health law that we have in the State of Massachusetts where the doctors have to take the Medicare coverage, and that law can possibly work in the State of Michigan.

With that, I want to thank you for giving me the opportunity to come up here and speak about those things that bother me, in fact they—because I work with people regardless of whether they're our UAW people. Region One has a resolution out and I'm sure the Senator has received it. We have over seven thousand here in the different communities that we've already sent in to the different representatives, our Congressmen, and our Senators. We sent it all the way through the whole country so that everyone should have it to support a National health program.

Thank you.

Mr. KRAWITZ. Sir, will you please restate your name for the record again?

Mr. GIBNER. My name is Kenneth Gibner and I'm out of Region One, Local 140.

Mr. KRAWITZ. Thank you, sir.

Your name, please?

STATEMENT OF MARIE WENTELA, FORMER COMMISSIONER ON AGING, SENIOR CITIZEN COUNSELOR

Ms. WENTELA. I'm Marie Wentela. I'm a former commissioner on aging and the last 11 years I've been in the City of Dearborn as a senior citizen counselor. So, I know a little bit about one on one, but I am now presently director of Senior Upreach Services for Dr. Coburn at the Coburn Clinic.

I'm here today representing Dr. Coburn because he cannot be here. Naturally, he's taking care of patients. So, I'm quoting from the letter that he wrote. He says this is still the same facts. He wrote to Senator Riegle March 25, 1987. And so I will give you the set forth record that's the only reason I'm reading it, and I'll quote from the letter where he was asking Senator Riegle's assistance.

EYE CARE FINANCING A MAJOR PROBLEM

As the provider of eye care for over 25,000 of your elderly constituents, I would like to tell you that near universal fear, confusion, and anger exists among them over the senseless and misguided attempts of our Government to effect budgetary economies by ill-conceived reductions in funding for surgical eye care.

The spectacular results of modern technology as regards cataract extraction and intraocular lens implantation are everywhere to be seen in our community. Elderly patients remain independent of family and social service assistance and involved in their community. Ophthalmology has changed the meaning of growing old in America and we have done it over 1 million times per year.

The Government's response to this revolution in health care has been mean-spirited and cynical. In the last one year: one, cataract surgical fees have been reduced by 12 percent.

Two, the Government has prohibited use of an assistant surgeon in virtually all cases. It is even illegal to provide an assistant surgeon to a patient who both desires it, a very realistic desire, and is willing to pay for it.

Three, anesthesia fees for cataract surgery have been reduced by 75 percent in our institution.

Four, the Peer Review Organization eliminated in patient cataract surgery. This has meant that elderly and crippled patients who live by themselves with no family assistance are unable to have cataract surgery.

Five, starting in October 1987, cataract surgery will be reimbursed to hospitals as 75 percent based on true cost and 25 percent based on the Ambulatory Surgery Center fee for cataract surgery which is $502 in Michigan.

That fee does not even come close to representing the true cost of providing surgery in an Ambulatory Surgery Center and certainly represents only a fraction of the true cost of hospital surgery.

This means that this legislation will produce a true loss to hospitals of $300 to $400 per case.

"I am the chairman"—this is Dr. Coburn speaking—I am the chairman of the Department of Ophthalmology at Straith Memorial Hospital and we are probably the busiest eye hospital in Michigan and we are certainly the lowest cost facility for hospital surgery in the State.

We have no way of subsidizing cataract surgery and this legislation, if implemented and passed, will mean that we will be forced to merge with a larger high cost institution which will have the effect of hugely increasing the health care cost for cataract surgery in Michigan. I doubt that more than a hand full of legislatures know the implications of this legislation on their communities and constituents.

Six, even more ominously, each and every cataract extraction will require certification by the Peer Review Organization some time this year. This will absolutely degenerate into rationing. This will essentially mean that every rejected cataract extraction which represents a patient desirous of improving his or her vision and a doctor who concurs with the patient in the need for cataract surgery, will require enlisting the aid of our representatives and senators.

The political implications of this legislation are horrible and the legislation cannot be sustained for more than 6 to 12 months whereupon the media and senior citizens groups will virtually demand its termination. It is simply not sustainable from a humanitarian or political stand point to victimize the elderly to save money.

The Federal Government created Medicare in order to guarantee access of senior Americans to quality health care. The social contract of this Government with its people is being violated and I—again, quoting, it is Dr. Coburn quoting—implore you to resist further cuts in Medicare funding for cataract surgery and prevent the Peer Review Organization from implementing their planned review.

Also, please prevent implementation of unwarranted and unacceptable cuts and hospital reimbursement that will have the effect of destroying some of the finest eye hospitals in the world.

I would greatly appreciate the opportunity to discuss this matter with you further at your convenience.

I wish to thank the Senator for encouraging your constituents here to become politically involved, letting their legislators know their needs and concerns.

I, myself, testified in 1979 before the House Appropriations Subcommittee in Washington in behalf of the seniors and behalf of the funds that were being cut out that would actually save the taxpayers money and thereby promote good health of the seniors. You know, I have a definition after all, a prejudice person is someone who's down on something they're not up on. So, let's all get involved.

Mr. KRAWITZ. Thank you very much.

Ms. WENTELA. I have also with me from Dr. Coburn's clinic, Miss Judy May. She is the director of the education, patient education. She's a very caring person just like Senator Riegle.

Mr. KRAWITZ. Thank you very much. Now, all of these people are waiting here in this row, are waiting to testify. Again, I ask—there are many people here, please try to keep your comments to 3 minutes.

I don't want to cut anyone off because I want everyone to have as much time as they need. But if I could—anything that's written will be inserted in the record and available to all the Members of Congress.

Your name for the record, sir?

STATEMENT OF MR. MELFORD O. PELECH

Mr. PELECH. My name is Melford O. Pelech, that's P-e-l-e-c-h.

Mr. KRAWITZ. Thank you, sir.

Mr. PELECH. I'm going to discuss the catastrophic illness cost. I've got a daughter 54 years old who is a total bedridden patient for approximately 3½ years. Part of her care in the first year was taken care of by hospitalization and insurance.

The insurance and hospitalization was taken away from us. She was left with a disability pension from the State of Michigan of $936. She was given a Social Security check of seven hundred and some dollars, I think it's $36. Then she receives a great amount of three hundred and some dollars from Aetna Insurance who was her carrier at the time of her illnesses and her injuries.

I, her father, accepted responsibility to take care of her to the amount of $264 per day for care; $848 per week, if there is no holiday. When the holiday comes, I have to pay double time for holiday care. This totals and costs me close to $100,000-per year.

I've got bills here showing, and there are records showing the cost of catastrophic illnesses and the care that these people need. Nobody is doing anything to help these people. Nobody is helping me.

Fortunately, I've been able to take and accumulate some money and I'm more than willing and glad to help my child. But how long can I take care of this? I have to care for her. She defecates in bed, she's lost the use of her left arm, she's losing the use of her right arm. She has no movement in her lower extremities. She has a folie. Nobody says hey, Mr. Pelech, can we help you? Can we do anything for you?

I also want to thank Senator Riegle's committee for sending me the invitation for coming here and appearing here today. I also want to state for the record that I will take at my own expense, go to Washington and testify before any committee, any group and as far as the President is concerned, I will testify before him and let him know that a 76 year old man is proud and will continue spending everything he's got until it's all gone to care for his child which no one else will do. Thank you.

Mr. KRAWITZ. Thank you.

STATEMENT OF ROSE MORENDEANY

Ms. MORENDEANY. Good afternoon, my name is Rose Morendeany. I'm from the City of Flint originally. I'm from Utica, Michigan as of now. As a matter of fact, I went to school with you, Sena-

tor, the class of 1956. You graduated, I graduated a year after. So, I can tell stories about you, so behave yourself.

Nonetheless, today I'm here on behalf of my parents, Joseph and Helen Morendeany. I now care for them. See, in 1971 my father had a stroke. At the age of 60 he was left paralyzed in his right side. His wife Helen has since cared for him until January 1987 when Helen, herself, entered the hospital for internal bleeding.

I began at that time caring for my father and when she had to be hospitalized very shortly and on March 17, a decision was made to enter him into a basic nursing facility which is a cost which was most destructive because the care was not proper.

On April 26, Joseph again entered the hospital, again for additional surgery due to a fall that was obtained in a nursing facility. On May 13, Joseph entered a skilled care nursing facility, costing $50,000 annually.

What is it going to cost 5 years from now; $100,000? Yes, we do have a problem. You see, more than the element here is when you have a family that you have to come together and then all of a sudden you have to tear apart their world.

My mother currently is residing with me. We have many things to address at this particular time. Basic care, nursing home needs to be addressed because that is a family devastation. The cost is prohibitive. And those of us who are not senior citizens such as you, Senator, and myself but rapidly approaching it, we need to address the education, the understanding. The pension programs that are currently being offered by corporations and those not being offered by corporations.

Nursing homes on the State level of course that has to be addressed on the State level. Providing quality nursing care as well as costs and what they are doing to rate their profits.

The Medigap that's sold by insurance agencies, by private pay to clients I would like to address. The only one who profits at this particular program are the insurance companies. I can attest to this because I have seen them work in the industry.

I teach people how to save money and fight the insurance costs. As you see, I come across people who are paying $17,000 a year for this so called Medigap insurance to pay for their nursing home and other help providing services, an atrocity what I have uncovered and I will continue to work to help senior citizens uncover this atrocity done by the insurance companies.

I feel at this time and I feel also in this great country no one should ever be reduced to zero money and poverty to receive quality of health care and nursing care.

A very important president of ours, Abraham Lincoln, stated united we stand, divided we fall. We senior citizens and those of us I will choose to represent must unite and stand and be taught to understand what they will face in the future. And those of us here today must learn that we will be in that situation come a very short time and who is going to care for us?

Thank you.

STATEMENT OF PATRICK DOYLE, MACOMB LIBRARY SUPPORT GROUP FOR THE BLIND, MACOMB COUNTY AREA

Mr. DOYLE. My name is Patrick Doyle and I'm here for myself, my mother and the Macomb Library support group for the blind and other blind people in the Macomb County area.

One of the problems that I have faced since 1965 is being on Medicaid. I am now on Medicare since 1980. I am a diabetic since 1965. I am 27 years old and since 1980 both Medicare and Medicaid have brought up an estimated $50,000 in debt. Whether there are two companies or two people that have helped me out in getting medications that are not covered or limited coverage, this has been a problem that has been going on for me and other diabetics.

I use to run a diabetic support group and there is no private insurance that will cover blood monitoring supplies or blood monitoring equipment other than Medicaid which is limited or Medicare. This has been a problem for diabetics since the development of new and better medical techniques and equipment. This has been a problem.

For my mother, she is a recovering cancer patient who works where she does at the St. Clair Shores Adult Ed, has limited medical coverage and sees her cancer specialist once every 4 to 6 months and the bills that are not covered at an office visit. The lab work is, but not the office visit or anything else that's not covered.

So, she can get hit with a $100 bill real quick and during the summer time she does not get paid. So whatever comes in through taking care of me and getting Chore Aid goes for paying the bills for the house and the whole routine.

For myself, I've endured a lot. People say I'm a stubborn Englishman. Well, they're right. I've been knocking my head up against the insurance companies checking on how I could get a job. Well, I don't have to worry about getting a job anymore. Now that I've got one, my doctor told me I'm not now or any time in the future employable. So, I'm stuck right where I'm at between Medicare and Medicaid on a very limited income basis.

For other blind people, we face the same problem that one person said earlier. You get red lined by insurance companies. If you are blind you have somewhat of a difficulty getting insurance. You've already got a health problem.

You're not going to get picked up by that company. I know people who are epileptic, diabetics, any number of medical problems. We all face the same thing. We've got to have coverage. The problem is can we afford it if we get it or can we get it then afford it.

The doctors right now that I have are willing to accept my insurances, but if I get a new doctor I don't ask does he accept Medicare, that is usually accepted by most doctors, not all but most. Medicaid is the problem.

If you've got Medicaid, you have to go far into the City of Detroit to a teaching hospital to get it. I won't go near one hospital for lack of training and lack of care. But the problem being that if you've got these insurances, you don't get everything covered like the one lady said earlier. It's not the best system. It's really not. The people that have it complain and it's an accurate complaint. It's not some-

thing just to get them to do or anything. They complain because insurances aren't picking up what they're suppose to any more.

Ten years ago Medicaid covered more than what it does now and I was 16 then. I'm 27 and they're not covering as much or nearly as much as they should. They give you the bear amount for the month.

But if your doctor says that you have to do blood monitoring eight or more times a day, Medicaid will only cover twenty-five strips a month. Medicare will pick up 80 percent of that bill, but Medicaid so far as I know will not touch the additional that Medicare does not in this area because they will only cover a small amount.

The things that are needed for blood monitoring are the test strips and land sets which will poke you in the finger tip. Not a pleasant thing to do. It's bad enough poking yourself as a diabetic with a syringe for the insulin, but when no insurance picks up land sets they can run anywhere from $12.50 per 200 land sets to $30 for 200. If you're doing it eight times a day, you need more than 200 a month and they don't come any smaller than 200.

This is a problem for diabetics, but it's also a problem for anyone else that has a major health problem. Diabetes is one, but it does a lot of damage, that's why I'm on disability.

The one problem I know that is a problem with Medicaid that's with State and Federally funded is that when I turned 21 I was going to have to reapply on Medicaid on my own status. Up until that point, I had been following it through from when I was a kid.

One drawback was they went back and scrutinized over a previous year where I had been admitted four times to the hospital via emergency in a 2-month period. I was living with friends. They are not medically trained and I was unconscious. Medicaid kicked things back for 3 years and I struggled for 10 months trying to prove that I did not commit Medicaid fraud.

In the meantime, none of my prescriptions were picked up, none of my doctor bills were paid, none of the hospital bills were paid. I had to scramble around for 10 months arguing with nothing more than a computer because in Lansing you can't get near anyone except for a copy.

I did it and I sweated and I sweated. Anytime—they never explained to me what it was. I kept getting Medicaid bills every month. I now have a different Medicaid worker. She still doesn't know what's going on. It's not her fault, but because of my situation I have Medicare and Medicaid. You have two different forms of red tape. The system is bad. We need an improvement. There is only one that I know of.

My dad was a resident in Canada. They had a national health system. My mother was raised in England. They still have the national health system. If I wanted to go there, I could. I still owe companies. I can't skip town on my debts. Unless I hit the lottery, I'm not going to get out of debt soon.

A national health system is needed.

STATEMENT OF PAULA MacIVER

Ms. MACIVER. I am Paula MacIver and I would like to thank Senator Riegle for holding this hearing.

My 79-year-old mother is in a nursing home with a diagnosis of Alzheimer's disease. She doesn't know my brother, she usually doesn't know me. She wanders aimlessly, would not remember to eat unless one of the staff takes her by the hand to the dining room and sits with her seeing that she eats. Sometimes she can handle a fork on her own, other times an aide must feed her.

If she had a deteriorating heart and had to be confined to a nursing home, there would be some insurance coverage. Yet because it is her brain that is being destroyed, she can get no help, as Alzheimer's disease is a terrible disease.

My father died in 1982 after a year as a bedridden invalid with a heart disease and diabetes. And that was a terrible situation for my mother. She had a minor heart attack at Christmas and was in cardiac intensive care for 4 days and then the step down unit for 7 more days. Because of Alzheimer's she couldn't remember why she was in the hospital.

She tried to remove the oxygen and the IV so they had to tie her hands and legs to the bed to hold her down. Because of Alzheimer's, she didn't have the capacity to understand and remember why she was tied down and she was terrified. Just imagine being tied down not knowing why or how long it would last.

My mother is now in the Chaulsey United Methodist Retirement Home which recognizes the needs of these people and has a special separate Alzheimer's unit. They are in a secured home-like wing on their own with their private room and their own furniture.

Their care is less expensive than a regular nursing home; has a duty nurse there part-time during the day to give out prescribed medications, but most of the care is provided by young trained aides who give love as well as assistance. She pays $47 a day which is about $18,000 a year which is less than the average.

The Government needs to encourage more units of this type by giving Medicaid and Medicare benefits to Alzheimer's benefits.

I appreciate the opportunity to speak.

Mr. KRAWITZ. Thank you for sharing that story.

STATEMENT OF BERTHOLD RAHN

Mr. RAHN. My name is Berthold Rahn. I really came here to say that I don't think that any health care change in care that doesn't cover nursing home should go through the Congress or Senate. It should be included and I'll tell you my personal story about it.

My wife at 77 in May had a stroke. She was about 50 percent paralyzed. After 3 or 4 months in different hospitals and then, the doctors all said let's face it, she just had one hell of a stroke and there's nothing you can do for it. You just have to take her home and take care of her the best you can.

So, I hired a nurse's aide to take care of her during the day. This here costs $200 a week. Then I quit working and took care of her for approximately 7 months. Then in November, October 1985 rather, the doctor said that she had to be confined to the bed. And as a man just said about going to the doctor, every time she had to

go to the doctor you had to call an ambulance and that was a $200 bill. That's $100 each way, back and forth.

And on January 8, 1986, she had a second stroke and this left her 98 percent paralyzed. She couldn't breathe on her own. She couldn't eat, can't talk. She's well aware of everything that's going on. She can't move any of her limbs and after being in the hospital for about 35 days, they put tube feedings in her throat and said that she couldn't be taken care of any way, any more unless she was in the nursing home or hospital. So, she's been in a nursing home since.

Now, this through Medicare benefit does pay the first 20 days and they practically pay nothing after that for a nursing home. Although they don't pay for her oxygen, I pay for it.

So, I actually get her nursing home bill that's about $2,500 a month for me and Medicare does pay for about a $1,000 for the supplies she gets. And I have to pay anywhere from $150 to $350 a month for medication for it. So, that's why I don't think that Medicare should make any changes unless they include personal nursing home.

And of course since she's been paralyzed so long and that, you know, I've seen a lot of small children that are in the hospital and they really need coverage too.

Now, actually I could tell you this much, since January 8th, being in the hospital and through April the 24th, her medical bills were $424,000 and a few cents. Now, out of that thank God for Medicare and Blue Cross. They paid $96,200 and I paid the rest. But if it keeps going on for another year or two I'll probably be on Medicaid.

Thank you, sir. That's all.

Mr. KRAWITZ. Thank you, sir. Who's next?

Will you state your name for the record?

STATEMENT OF PIT WICKINSON, GRAY PANTHERS

Mr. WICKINSON. My name is Pit Wickinson and I'm a member of the Gray Panthers. I'd just like to point out 28 years ago I was denied just under $3,500 of medical treatment, so I'm functionally blind due to that.

The real statement I wanted to make was to bring this up about the world that the other industrial advanced nations, the University of Pennsylvania does a continuing 5-year study about the quality of life throughout the world and the results came out in the fall of 1982. Of course it was on the national news 3 nights a week. They just give you a flash of it.

At that time, Denmark was No. 1 in the quality of life; we were only 41; of course, Ethiopia was 164. Now, the next set of results will be out this fall of 1987. It will be interesting to look at that. If a little nation like Denmark can up the quality of life, it must mean that all these other 40 nations must have some form of national health plan which contributes a hell of a lot to the quality of life.

And I think that Senator Riegle and anyone in here should look for those results or write to the University of Pennsylvania for the next set coming out in the fall of 1987. Enough said.

Mr. KRAWITZ. Thank you.
Your name, sir?

STATEMENT OF LEONARD DAVIS

Mr. DAVIS. Leonard Davis from Mount Clemens, Michigan. I have some information too for that lovely young lady on the left. I also would like to thank Senator Riegle, the staff and the stenographer for all your patience. I would like to make two statements, one is in regard to myself.

I'm 59 years young, but I've been ill since 1981 with coronary vasospasms and unstable lagena. I never heard of it before that. I received my Medicare in 1984 just before I almost lost my home and all my possessions. I'm now covered by Medicare and retired from Chrysler with a pension. And with Medicare disability and my lovely wife of 33 years, I'm able to sustain and keep my head above water.

However, Chrysler has been sending me packages that says Blue Cross/Blue Shield health care benefits designed with you in mind. I shudder whenever I see that because little by little my benefits are being eroded because the companies want to go to less expensive health care benefits for people that are working, people that are retired, and people on disability.

And I have here, I'm not going to read it, but Detroit News Saturday, May 30, 1987, "Chrysler To Bill Some for Health Care".[1] I'm already being billed.

Medicare is billing me. I pay a monthly premium and that's going up. I also pay hospitalization for major medical for Chrysler and that's going up. Now they want to bill me if I read this right $10 a month for additional Medicare or I mean Blue Cross/Blue Shield because they want me to switch to a PPO or HMO which is cheaper for them, but which involves more expenses for myself and my family.

If I have to go to another hospital and go through what I've been going through for the last 5 or 6 years, it would be a catastrophe for me. I was released yesterday for the 43d time from Mount Clemens General Hospital. I had to come here today to testify or let somebody know what's going on.

My wife has congenital heart disease, she has diabetes and she has other problems, yet she is working and maintaining my house. And without her by my side, I don't know what I would do. But everything is going up by 62 or by 65 percent. I'm fearful of what's going to happen to all these benefits that are being eroded all the time.

I think I have a catastrophic disease. I don't know what anybody else thinks, but I feel that I have, and I would like to see help for myself as well as for all these others.

Thank you.

Mr. KRAWITZ. Thank you, Mr. Davis, and we'll make your material part of the hearing record.

[The following was submitted for the record by Mr. Davis:]

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[1] See p. 118.

PATIENT: LEONARD W. DAVIS — AT HOME: (313) 791-5109

WIFE: KATHLEEN E. DAVIS — AT WORK: (313) 343-4000
ST. JOHN HOSPITAL
SWITCHBOARD OPERATOR

ADDRESS: 22945 LINNE DRIVE
MT. CLEMENS, MICHIGAN 48043

PHYSICIAN: DR. CRAIG N. NORRIS D.O.

HOSPITAL: MT. CLEMENS GENERAL HOSPITAL

DIAGNOSIS: UNSTABLE ANGINA
CORONARY VASOSPASMS
MULTIPLE P.V.C.'S

MEDICATIONS:

VERAPAMIL - 80 MG - (1) TABLET - 3 TIMES DAILY - 6:00 A.M.- 2:00 P.M.- 10:00 P.M.

PERSANTINE - 50 MG - (1) TABLET -3 TIMES DAILY - 6:00 A.M.- 2:00 P.M.- 10:00 P.M.

DILITRATE - 40 MG - (2) CAPSULES- EVERY 8 HOURS- 6:00 A.M.- 2:00 P.M.- 10:00 P.M.

LIBRAX - (1) CAPSULE - 5MG- 3 TIMES DAILY - 6:00 A.M.- 2:00 P.M.- 10:00 P.M.

NORPACE - (1) CAPSULE- 100MG- 4 TIMES DAILY - 6:00 A.M.-12:00 P.M.-6:00 P.M.- 12:00 AM

ISORDIL - 5MG - 2 TABLETS - SUBLINQUAL - EVERY 3 HOURS- WHILE AWAKE - UNDER THE TONGUE
6:00 A.M.-9:00 A.M.- 12:00 P.M.-
3:00 P.M.-9:00 P.M.- 12:00 A.M.

DYAZIDE - (1) CAPSULE- DAILY - 10:00 A.M.

TRANSDERM - NITRO - 5MG - (1) PATCH - DAILY - PUT ON 10:00 A.M.- TAKE OFF 10:00 P.M.

TYLENOL #3 - (2) CAPSULES - AS NEEDED FOR PAIN

MYLICON - 80 MG. CHEWABLE TABLETS - (1) OR (2) AFTER MEALS AND/OR PRN

ULTERNAGEL - AS NEEDED FOR INDIGESTION

ALLERGIC (ADVERSE SIDE EFFECTS) TO THE FOLLOWING MEDICATIONS:

TAGEMET

CARDIZEM

MYLANTA

PATIENT: LEONARD W. DAVIS - EMERGENCY ROOM AND/OR HOSPITALIZATION DATES

MOUNT CLEMENS GENERAL HOSPITAL
(OSTEOPATHIC)
1000 HARRINGTON
MOUNT CLEMENS, MICHIGAN 48043

DATE OF ADMISSION		DATE OF DISCHARGE	
3-19-84	OUTPATIENT	3-19-84	LOW LEVEL STRESS TEST - BLOOD TESTS (DR. JOHN A. FRAHM)
4-25-84	INPATIENT	4-28-84	CHEST PAIN - VASOSPASMS
5- 2-84	ER	5- 2-84	CHEST PAIN - VASOSPASMS
7-19-84	INPATIENT	7-22-84	CHEST PAIN - VASOSPASMS
11-26-84	INPATIENT	11-29-84	CHEST PAIN - VASOSPASMS
3- 3-85	INPATIENT	3- 6-85	CHEST PAIN - VASOSPASMS
11-22-85	OUTPATIENT	11-22-85	BIOPSY - LEFT BREAST (DR. CLIFFORD W. ISAAC)
4- 1-86	INPATIENT	4- 4-86	CHEST PAIN - VASOSPASMS
4-17-86	INPATIENT	4-20-86	CHEST PAIN - VASOSPASMS
5-20-86	INPATIENT	5-22-86	HEART CATHERIZATION (DR. ANTON H. WESTVELL)
8-23-86	INPATIENT	8-28-86	CHEST PAIN - VASOSPASMS
1-16-87	OUTPATIENT	1-16-87	LOW LEVEL STRESS TEST- BLOOD TESTS (DR. JOHN F. KAZMIERSKI)
1-23-87	INPATIENT	1-26-87	CHEST PAIN - VASOSPASMS
2-19-87	OUTPATIENT	2-19-87	PULMONARY FUNCTION TEST (MCG REHAB.)
2-25-87	INPATIENT	2-26-87	CHEST PAIN - VASOSPASMS
3-10-87	OUTPATIENT	3-10-87	LOW LEVEL STRESS TEST- BLOOD TESTS (DR. JOHN F. KAZMIERSKI)
3-11-87	OUTPATIENT	3-12-87	HOLTER MONITOR MCG REHAB.)
4-21-87	INPATIENT	4-30-87	CHEST PAIN - VASOSPASMS
5-28-87	INPATIENT	5-31-87	CHEST PAIN - VASOSPASMS

PATIENT: LEONARD W. DAVIS - EMERGENCY ROOM AND/OR HOSPITALIZATION DATES

MOUNT CLEMENS GENERAL HOSPITAL
(OSTEOPATHIC)
1000 HARRINGTON
MOUNT CLEMENS, MICHIGAN 48043

DATE OF ADMISSION		DATE OF DISCHARGE	
6- 3-81	INPATIENT	6- 8-81	CHEST PAIN - VASOSPASMS
7- 3-81	INPATIENT	7-18-81	CHEST PAIN - VASOSPASMS REMOVAL OF GALL BLADDER
8-15-81	ER	8-15-81	CHEST PAIN - VASOSPASMS
9- 8-81	INPATIENT	9-15-81	CHEST PAIN - VASOSPASMS
11- 2-81	INPATIENT	11-12-81	CHEST PAIN - VASOSPASMS
1- 7-82	INPATIENT	1-14-82	CHEST PAIN - VASOSPASMS
1-14-82	ER	1-14-82	CHEST PAIN - VASOSPASMS
5-21-82	INPATIENT	5-31-82	CHEST PAIN - VASOSPASMS
6- 5-82	INPATIENT	6-10-82	CHEST PAIN - VASOSPASMS
7-27-82	ER	7-27-82	CHEST PAIN - VASOSPASMS
8-11-82	INPATIENT	8-15-82	CHEST PAIN - VASOSPASMS
10-14-82	INPATIENT	10-22-82	CHEST PAIN - VASOSPASMS
1- 9-83	INPATIENT	1-18-83	CHEST PAIN - VASOSPASMS
2- 8-83	INPATIENT	2-14-83	CHEST PAIN - VASOSPASMS
3-26-83	INPATIENT	4- 6-83	CHEST PAIN - VASOSPASMS
5- 1-83	INPATIENT	5- 6-83	CHEST PAIN - VASOSPASMS
5-22-83	INPATIENT	5-26-83	CHEST PAIN - VASOSPASMS
5-27-83	INPATIENT	6- 3-83	CHEST PAIN - VASOSPASMS
6-27-83	INPATIENT	7- 1-83	CHEST PAIN - VASOSPASMS
7-27-83	INPATIENT	8- 4-83	CHEST PAIN - VASOSPASMS
8-14-83	INPATIENT	8-20-83	CHEST PAIN - VASOSPASMS
11-24-83	INPATIENT	12- 2-83	CHEST PAIN - VASOSPASMS
1-14-84	ER	1-14-84	CHEST PAIN - VASOSPASMS
2-21-84	INPATIENT	2-24-84	CHEST PAIN - VASOSPASMS

PATIENT: LEONARD W. DAVIS - OFFICE VISITS & MEDICAL MANAGEMENT DURING HOSPITALIZATION

GENERAL HOSPITAL MEDICAL ASSOCIATES P.C.
21550 HARRINGTON, SUITES B & E
MOUNT CLEMENS, MICHIGAN 48043
PHONE: (313) 468-8500

	DATE TREATMENT BEGAN	DATE LAST TREATMENT	
DR. JOHN A. FRAHM D.O.	10-23-84	10-23-84	
DR. JOHN A. FRAHM D.O.	2- 5-85	2- 5-85	
DR. JOHN A. FRAHM D.O.	3- 3-85	3- 6-85	
DR. JOHN A. FRAHM D.O.	4- 5-85	4- 5-85	
DR. JOHN A. FRAHM D.O.	6-11-85	6-11-85	
DR. ANTON H. WESTVELD D.O.	8-19-85	8-19-85	
DR. MARY E. PULS D.O.	10-28-85	10-28-85	
DR. MARY E. PULS D.O.	11-11-85	11-11-85	
DR. MARY E. PULS D.O.	1- 6-86	1- 6-86	
DR. MARY E. PULS D.O.	1-13-86	1-13-86	
DR. MARY E. PULS D.O.	4-15-86	4-16-86	24 HOUR HOLTER MONITOR
DR. MARY E. PULS D.O.	5- 1-86	5- 1-86	
DR. CRAIG N. NORRIS D.O.	9-16-86	9-16-86	
DR. CRAIG N. NORRIS D.O.	12-16-86	12-16-86	
DR. CRAIG N. NORRIS D.O.	1-23-87	1-26-87	
DR. CRAIG N. NORRIS D.O.	2- 6-87	2- 6-87	
DR. CRAIG N. NORRIS D.O.	2-25-87	2-26-87	
DR. CRAIG N. NORRIS D.O.	3- 3-87	3- 3-87	
DR. CRAIG N. NORRIS D.O.	4-21-87	4-30-87	

PATIENT: LEONARD W. DAVIS - OFFICE VISITS & MEDICAL MANAGEMENT
DURING HOSPITALIZATION

GENERAL HOSPITAL MEDICAL ASSOCIATES P.C.
21550 HARRINGTON, SUITES B & E
MOUNT CLEMENS, MICHIGAN 48043
PHONE: (313) 468-8500

	DATE TREATMENT BEGAN	DATE LAST TREATMENT	
DR. JOHN A. FRAHM D.O.	5- 1-83	5- 6-83	
DR. JOHN A. FRAHM D.O.	5-11-83	5-11-83	
DR. JOHN A. FRAHM D.O.	5-22-83	5-26-83	
DR. JOHN A. FRAHM D.O.	5-27-83	6- 3-83	
DR. JOHN A. FRAHM D.O.	6-15-83	6-15-83	
DR. JOHN A. FRAHM D.O.	6-27-83	7- 1-83	
DR. JOHN A. FRAHM D.O.	7-20-83	7-20-83	
DR. JOHN A. FRAHM D.O.	7-27-83	8- 4-83	24 HOUR HOLTER MONITOR
DR. JOHN A. FRAHM D.O.	8-14-83	8-20-83	
DR. JOHN A. FRAHM D.O.	9-21-83	9-21-83	
DR. JOHN A. FRAHM D.O.	10-19-83	10-19-83	
DR. JOHN A. FRAHM D.O.	11-24-83	12- 2-83	
DR. JOHN A. FRAHM D.O.	12-21-83	12-21-83	
DR. JOHN A. FRAHM D.O.	1-18-84	1-18-84	
DR. JOHN A. FRAHM D.O.	2-21-84	2-24-84	
DR. JOHN A. FRAHM D.O.	3-14-84	3-14-84	
DR. JOHN A. FRAHM D.O.	4-25-84	4-28-84	
DR. JOHN A. FRAHM D.O.	5- 2-84	5- 2-84	
DR. JOHN A. FRAHM D.O.	6- 7-84	6- 7-84	BLOOD TESTS
DR. JOHN A. FRAHM D.O.	6-13-84	6-13-84	
DR. JOHN A. FRAHM D.O.	7-19-84	7-22-84	
DR. JOHN A. FRAHM D.O.	9-11-84	9-11-84	

PATIENT: LEONARD W. DAVIS - OFFICE VISITS & MEDICAL MANAGEMENT DURING HOSPITALIZATION

GENERAL HOSPITAL MEDICAL ASSOCIATES P.C.
21550 HARRINGTON, SUITES B & E
MOUNT CLEMENS, MICHIGAN 48043
PHONE: (313) 468-8500

	DATE TREATMENT BEGAN	DATE LAST TREATMENT	
DR. JOHN A. FRAHM D.O.	6- 3-81	6- 8-81	
DR. ANTON H. WESTVELD D.O.	6-24-81	6-24-81	
DR. JOHN A. FRAHM D.O.	7- 3-81	7-15-81	24 HOUR HOLTER MONITOR
DR. JOHN A. FRAHM D.O.	9- 8-81	9-15-81	
DR. JOHN A. FRAHM D.O.	11- 2-81	11-12-81	24 HOUR HOLTER MONITOR
DR. A. LEWIS KATZOWITZ D.O.	1- 7-82	1-14-82	24 HOUR HOLTER MONITOR
DR. ANTON H. WESTVELD D.O.	5-21-82	5-31-82	
DR. W. DALE RANKIN D.O.	6- 4-82	6-10-82	
DR. JOHN A. FRAHM D.O.	6-23-82	6-24-82	24 HOUR HOLTER MONITOR
DR. JOHN A. FRAHM D.O.	8-11-82	8-15-82	24 HOUR HOLTER MONITOR
DR. JOHN A. FRAHM D.O.	9- 8-82	9- 8-82	
DR. JOHN A. FRAHM D.O.	10-14-82	10-22-82	
DR. JOHN A. FRAHM D.O.	11-10-82	11-10-82	
DR. JOHN A. FRAHM D.O.	12- 8-82	12- 8-82	
DR. JOHN A. FRAHM D.O.	1- 5-83	1- 5-83	
DR. JOHN A. FRAHM D.O.	1- 9-83	1-18-83	
DR. JOHN A. FRAHM D.O.	2- 2-83	2- 2-83	
DR. W. DALE RANKIN D.O.	2- 8-83	2-14-83	
DR. JOHN A. FRAHM D.O.	3-16-83	3-16-83	
DR. JOHN A. FRAHM D.O.	3-26-83	4- 6-8[illegible]	
DR. JOHN A. FRAHM D.O.	4-20-83	4-20-8[illegible]	

[From the Detroit News, May 30, 1987]

CHRYSLER TO BILL SOME FOR HEALTH CARE

WORKERS WILL PAY FOR HIGH-COST PLANS

(By James V. Higgins)

Chrysler Corp. salaried workers who choose health and dental care plans labeled as too expensive by the automaker will be required to pay part of the costs, including monthly insurance premiums as high as $35.

That's part of a major new move by Chrysler to cut health care costs by encouraging its white collar workers and retirees to select less expensive plans.

Details were spelled out in letters mailed earlier this month by Anthony P. St. John, Chrysler's vice-president for human resources.

A Chrysler spokesman confirmed that the letters were mailed to 34,000 active and retired salaried employees but declined further comment. The measures don't apply to UAW-represented workers at Chrysler.

In essence, Chrysler told salaried workers in certain areas, including Southeast Michigan, that Blue Cross/Blue Shield medical plans are too expensive and offer fewer benefits than the other options offered—enrollment in Health Maintenance Organizations and Preferred Provider Organizations.

Those who choose to keep the Blue Cross/Blue Shield coverage will be billed monthly premiums of $35 for active workers, $24 for retirees without government-sponsored Medicare benefits and $10 for retirees with Medicare benefits.

When health-care options were renewed last year, the letter said more than 46 percent of eligible employees and retirees chose the less expensive HMO and PPO plans.

In the past, many workers have been reluctant to choose the alternative plans because they can no longer see family doctors—they must go to a physician participating in the HMO or PPO.

"We have concluded that, as Chrysler continues its search for ways to become more competitive, it should not continue a policy which has it paying more for a benefit plan that offers employees and retirees less benefits," the letter said. "Such a policy simply does not make a whole lot of sense."

In addition, those who select the standard dental-care plans instead of less expensive alternative plans will be required to make annual deductible payments ranging from $50 for a single person to $150 for a family plan. Co-payments will be required for certain dental treatments or will be increased for others.

The letter said Chrysler's overall health care costs will approach $500 million this year. Even if all salaried workers choose less expensive medical and dental-care plans, Chrysler said it will spend more than $3,000 per employee per year for those plans.

Mr. KRAWITZ. Ma'am, again, I appreciate all of you that have waited so long to testify.

STATEMENT OF MISS BEAULAH LIGON

Ms. LIGON. I am Beaulah Ligon, L-i-g-o-n. I meant to speak on the care of the aged and you covered my main points, so I'm going to speak on two points nobody has testified on.

This summer I had a neighbor, the manager at the apartment complex asked me to pick up his rent and bring it over because he was unable to bring it over. I took it over and I would say Joe, is there something that I could buy for you, something I could get for you? His answer was always no.

He had always been a loner since he had lived there. One day he fell on his wife's coffee table and after that, she had been dead 9 years from heart trouble. He had been an electrical engineer in Chicago until his wife became so ill with heart trouble he had moved here to be near his daughter who is an R.N. And that dear man was taken to the hospital and pronounced dying with malnutrition.

He had three daughters who were R.N.'s, nine grandchildren. One daughter sold her home because he wouldn't move in with her that minute and bought a yacht, was up on the Great Lakes Yachting, built a new home out in Arizona, and just a few days it took to heal the wounds on his head and arms, he was sent to Avondale Nursing Home.

I began going to see him over there. I was afraid to go to the hospital, so many darn doctors are harmful at hypnosis and I began taking him turkey soup which he liked best of anything to eat, crackers and a ripe banana.

One time I was there his grandson and wife were there and before he went into the hospital it had been 3 weeks since his grandson had come to see him. Can you imagine now he didn't have anything to eat to speak of.

I took him down an orange and banana and ripe nectarine. He said I'm not going to eat that. Well, he loved the turkey soup. And the rest of the time I went nobody was around anywhere. On a Friday night I took him soup and stayed about 2 hours and I knew he was worse.

I helped him get back to bed, covered up his feet, he was fully dressed. I said Joe, shall I move the television set over for you? No, give me the string on the little radio. I put the string on the radio beside the bed and turned his table around so he could use the napkins and so on. And I left him and I said God be with you until we meet again. And this dear kind refined gentleman said you too. He died the next night with pneumonia fever and his daughters knew he had a very bad cold and died with malnutrition. He died that night with a heart attack from pneumonia fever.

Now, I would like to see a law made where nobody inherits one red cent when they let a close relative of there's die with malnutrition. He had a Cadillac in the car port and lovely furniture in the house and I'm sure plenty of money in the bank.

The children certainly had plenty of money to take care of that man. He was a wonderful human being you never knew. He was a loner at the apartment that's all we could say. Nobody was ever invited over his door. He would talk to you out in the hall but that was about all.

When I first went to see him I said I got your cards today, with that I will drop the story. But, I'll never forget Joe dying with malnutrition.

In 1949, when I was getting my Master's at that evil University of Michigan, Dr. Barlow Hughes on the last day of the term hurt me under hypnosis until he almost killed me, just so he could force me to go to a psychiatrist to be used for a research guinea pig for the next world war because Hitler controlled the Germans with hypnosis during World War II; that is, I'd say the Lutheran Germans who had a little religion in their souls. The rest of them didn't need hypnosis.

And since then, I've gone through so much horror and so much torture your mind couldn't comprehend it. The first doctor made me relive the experience with Hughes.

Well, Hughes hurt me so horribly that I broke out in hives and black spots as big as a quarter from my waist down and puss pockets as big as my little finger. When Dr. Steinball got to my apart-

ment in Palmer Park, he said I was the worse looking human being he'd ever seen in his whole life.

Well, it took me several weeks to get over those hives and several weeks before I was able to go down to his office. He had to come see me. The next thing that happened, I guess was Dr. Steinball enlarged my heart by telling me a fear of disc story under hypnosis.

The only travel trip I've been able to afford out of 40 years of teaching and 14 months of working for the Ford Motor Company during World War II was 3 weeks of the second summer when my heart was suffering so badly they thought if I took a trip it would get my mind off it and I would feel better and I did. It didn't cure the heart, but it got better over the years.

Since then, I been connected with a little dog sexually with the next doctor. Now the next doctor was an alcoholic. I helped him overcome 22 years of alcoholism by having anti-breathing classes in Illinois taught me how to detect school behavior problems and school learning problems. How to—I'm getting blocked. How to detect and counsel school learning and school behavior problems, but I had a very dedicated master teacher and some of his skill rubbed off on to me.

This alcoholic psychiatrist was bleeding and I don't know why he had horrible vomits of blood. One little boy said in the fourth grade doctor so and so drinks too much booze. Not knowing much about liquor, I didn't know he was drinking. I just thought he was a sick man. I at first thought he was a good man.

I helped him overcome those 22 years of alcoholism and in the process found out why he became an alcoholic. And because I found out why he became an alcoholic, he indirectly told me one day when he was drinking, wanted to be funny, you know, some alcoholics get funny occasionally. He was a little man, a lot younger than me. I felt more or less like an aunt toward him, I guess. He was kind and nice until about this time then he starts to get cruel.

And I got him out of the office—you ever seen Dr. Nia. He even had the covering pulled completely off his couch. Big spots of dried blood on the back of the seat and a suite with nine people working under him. This suite was nicely furnished.

Mr. KRAWITZ. Excuse me Miss, there are other people who are waiting, could you summarize your comments for us, please?

Ms. LIGON. Well, I've been programed to commit suicide by this doctor and I cannot go to a doctor today usually unless he hurts me with hypnosis. And one doctor 4 or 5 years ago pulled out although hurt at one time and talked about how—I'm so terrified of doctors that my own bed and bedroom is my hospital room and I wet on myself.

I have nobody to look after me or nobody to care for me or help me. My father was killed when I was 8 and my mother has been dead for several years and I never married because I had the responsibilities of rearing my father's family and rearing my way through school and taking care of mother. Professor William——

Mr. KRAWITZ. I'm going to have to relinquish the microphone.

Ms. LIGON. I'll go now, sir, and save you. Evidently you don't want to hear my story.

Mr. KRAWITZ. We would love to hear your story.

Ms. LIGON. This is for all humanity. I hurt all over as if pins and needles were being pinched into my body in every tiny space there was for several days and nights.

And during that I had an acute myocardial infarction at home all alone with just telephones to crisis counselors. When I called Professor William Coon, 4 years ago, he was C-double o-n—he was doing, he was a surgeon in the United States, could take in the patients in the United States while they were sick or undergoing surgery. He could hypnotize them without their knowledge or consent, either say one negative sentence and kill them and it's not illegal.

Mr. KRAWITZ. Thank you very much.

Ms. LIGON. Let me say another word or two. You called the—the woman told me if we had a law that we could make it a felony for a doctor or anyone else to use hypnosis harmfully on anyone and the law to make it a felony for——

Voice. This lady has a husband on a respirator at home.

Mr. KRAWITZ. Thank you, ma'am.

Ms. LIGON. Do you realize I could die with a heart attack going home? I had a stroke in this thigh just last week. I've had four strokes in this leg and two strokes in this hand, all brought on in the last 1 year.

Mr. KRAWITZ. Thank you very much. We're going to have other people who have been waiting have an opportunity to testify.

Will you please state your name for the record?

STATEMENT OF MS. DROZDOWSKI

Ms. DROZDOWSKI. I'm Ms. Drozdowski from Clarkston, Michigan and I'm speaking on behalf of my husband who can't be here because he's in the hospital on a respirator. I want to say thanks to Senator Riegle and his staff for allowing me to come here.

I want to say that my husband is in the hospital at the expense of $18,000 a day. He not only has been hospitalized for respiratory problems, but he has a multiple of other problems like Alzheimer's, a bad heart, arthritis, chronic pancreatitis; not to mention a mental condition and only $10,000 incurred by insurance. He's been in the hospital since January 11, 1987, with a respirator with a 5-percent chance of getting off the respirator due to the emotional stress he's going through.

He's been disabled since 1970. He's been in many hospitals approximately 25 times and not to mention the clinics. He's had many surgeries. He's gone from a wheelchair to a ventilator. The home care cost would run a cost of $22,000 a month. His Medicare has been used up some time ago, including his life time reserve days. Had it not been for additional coverage, we would have been drained long ago.

However, his only insurance will only last until December, then what does he do and where does he go and who will be taking care of him? As his doctor indicated, he gets into trouble frequently being on a respirator and it would be very difficult for me to care for him and give him the care he needs.

He is depressed and emotional, but yet has a desire to want to live. I've taken care of him since 1970, but he needs long-term care.

I've been told by the hospital that being on a respirator would not be able to include catastrophic care only certain other illnesses.

Four dollars a month is a very small expense opposed to $18,000 a day the current hospital cost for my husband's care.

Thanks for allowing me to take your time.

Mr. KRAWITZ. Thank you very much. I appreciate the fact that you've waited.

Please state your name for the record.

STATEMENT OF JIM PERRY

Mr. PERRY. My name is Jim Perry and I live in Grosse Point Woods. I want to thank Senator Riegle and you David Krawitz, and Joan Huffer, and the stenographer for all your patience today.

I think it has been very enlightening for all of us to attend this meeting and I hope that Senator Riegle can pass the word on to the other senators that I think it would be nice if they would have a hearing such as this in their State and thereby I think we would have much more strength with that thought in mind. And I would like to say that nursing home care in general, not only my opinion, but from what I've heard from a lot of other people is very expensive and not only is it expensive, but the quality in a lot of cases leaves a lot to be desired. It's been on my mind why couldn't we have Government nursing homes per se one to possibly whatever could be afforded. At least one in each State. Possibly four would be the ideal situation, a north, east, south and west. By having national health care which I think, of course, Senator Riegle is aware of it so is the staff, this is what we need in the United States. From what I first heard here today about Denmark being No. 1, being a small Country setting the example, I sure think we could follow that example. And getting back to the Government nursing homes, we could have it staffed with qualified doctors and qualified nurses and being run under Government medical and health care rules which I think would give the people better care and again I'm saying for all ages; the young as well as the elderly.

And I want to thank you for according me this time to speak here today. Thank you.

Mr. KRAWITZ. Thank you.

[The following was submitted for the record by Mr. Perry:]

JUNE 1,1987

U.S. SENATOR DONALD W. RIEGLE, JR.
UNITED STATES SENATE
WASHINGTON, D.C. 20510

DEAR SENATOR:

I WOULD LIKE TO SUBMIT THE NAME OF DAVID T. VESCO, M.D. AS THE LIKELY NUMBER ONE CANDITATE TO REPRESENT THE STATE OF MICHIGAN NOT ONLY IN THE MICHIGAN SEQUICENTENNIAL NATIONALLY BUT ALSO IN THE 200TH. YEAR CELEBRATION OF OUR CONSTITUTION. DR. VESCO WOULD LIKE TO MEET WITH YOU AND THE PRESIDENT. THE THOUGHT OF A PICTURE OF YOU DR. VESCO AND PRESIDENT REAGAN WITH A UNITED PRESS PICTURE COUPLED WITH HIS LIFE STORY AND HIS ESCAPE FROM BEHIND THE IRON CURTAIN.

ENCLOSED YOU WILL FIND THE VERY INTERESTING BIOGRAPHY OF DAVID T. VESCO, M.D. WHO YOU WILL FIND IS A VERY HUMBLE PERSON BUT VERY INTERESTING TO TALK WITH.

I HAD CONTACTED YOUR LOCAL OFFICE LAST YEAR ABOUT HIM REPRESENTING MICHIGAN IN STATUE OF LIBERTY CELEBRATION IN NEW YORK. THEY SAID HE WOULD HAVE BEEN THE NUMBER ONE CANDIDATE BUT DR. VESCO HAD NOT YET ENOUGH TIME IN TO BECOME A CITIZEN. HE BECAME A CITIZEN NOVEMBER 1986.

SENATOR HERE IS A MAN THAT RISKED HIS LIFE FOR HIS AMERICAN DREAM AND CAME TO MICHIGAN TO WORK AT ST. JOSEPH'S MERCY HOSPITAL IN PONTIAC, MICHIGAN ! THE PIONEER SPIRIT GOES ON, IT IS NOT DEAD!"

DR. DAVID T. VESCO CAN BE REACHED AT ST. JOSEPH'S MERCY HOSPITAL IN PONTIAC BY CALLING 313-858-3000 PAGE #1078.

THANK YOU FOR YOUR KIND ATTENTION TO THIS IMPORTANT MATTER THAT WOULD BE OF GREAT INTEREST TO CITIZENS OF THE STATE OF MICHIGAN AND THE PEOPLE OF THE UNITED STATES OF AMERICA !

WILL YOU PLEASE RESPOND TO THIS LETTER AS SOON AS POSSIBLE ?

IF I CAN BE OF FURTHER ASSISTANCE TO YOU PLEASE DON'T HESITATE TO CONTACT ME.

SINCERELY,

JAMES H. PERRY
1765 PRESTWICK RD.
GROSSE POINTE WOODS, MI
48236

313-884-0021 RES.

7:30 A.M. TO 10:30 P.M.

DREAM OF AMERICA COMES TRUE

The Dream of America has come true for a man who escaped from behind the Iron Curtain!

David T. Vesco, M.D. was born in Thrace, in the Valley of the Roses, which has been famous throughout the world for its attar of roses and for its thermal and mineral springs, some of the finest in Europe.

The Romans built Spas there to bath and to drink thermal and mineral water to help with their kidney diseases. You can still see the Roman Ruins of some of the largest Spas ever built in Europe.

As a young boy growing up in Thrace, Bulgaria David Vesco was reared by parents who were against Communism. His father was an attorney who tried to defend opponents of Communism and because of his efforts was put into a Concentration Camp for four years!

David had no real friends among his peers because of his family's position on Communism. Because of this, David devoted most of his free time to study and worked very hard to attain top honor student in his class and his school. He graduated from High School at age 15 with top honors.

David's Mother was Professor of Mathmatics and Physics and also was involved in Herbal based medicine and Herbal based cosmetics and beauty preparations. David Vesco grew up imbued with her entrepreneurial spirit and steeped in the atmosphere and activities of the Spa. From her he learned many things about the properties of different plants and minerals, about herbal extracts and compounds, and about proper care of the body. It was his Mother who directed him toward the study of Medicine.

He took his test for Medical School at age 15. After successfully passing his test with high grades entered first year of Medical School September 1. The first and second years were spent with basic Medical School and experimenting in chemistry and bio-chemistry.

Entering Medical School at only 15 put him in a class with students 18 years and up. The older students made fun of him and joked about him. They said he was too young to go out on dates with girls. In addition to being young he was also still on the small side. So, David Vesco put his time outside the classroom into long hours of study in which he had always been accustomed to at home. David gained a lot of knowledge from French Books. He soon rose to the top of his class academically. Soon after the joking about the boy-medical-student stopped and some of his fellow students were seeking his help with their subjects. He had earned their respect! In college David played tennis and was 3rd racket.

After seven years of Medical School, David T. Vesco graduated with top honors and received his Diploma and M.D. Certification at the age of 22. He was then drafted into the Communist Air Force as a Paratrooper in training under Russian guidance. Basic training lasted six months. He made jumps near the sea in Bulgaria and in Russia he jumped in the mountains and skied through the mountains.

He was then assigned to a Paratrooper Division and received a Commission as Lieutenant and Medical Doctor in his outfit. This duo roll of Paratrooper and M.D. caused him to have a bitter experience. One of the fellow para-troopers had become very ill. Due to the outfits limited medical facilities Dr. Vesco sent him to the hospital, which happened to be several miles away from the camp. Within a short time the entire outfit was put on alert

because of a crisis between Greece and Turkey. The officer in charge, upon finding that one of his best rocket launchers was in the hospital, off the base, and had been sent there by Lt. Vesco, became extremely angry. He called for drastic punishment and Vesco was confined to a small cell underground for ten days. After two years in the Military, he was discharged with the rank of Captain.

He then took an exam for training in Neurology. This he studied for four years and again passed with top honors. Dr. Vesco became an Assistant Proffessor of Neurology at the University of Ivan Paulou. He honed his craft by practice and study. He gained broad experience in many areas of medicine and carried out neurological consultation to other hospitals in the Southern part of Bulgaria.

He continued his scientific research, including presentation of a paper on the differing effects on human skin and internal body structures of pollution versus clean air, plus another scientific project which involved experiments with different emmolients, allergies of the skin, aging of the skin.

After a number of years Dr. Vesco decided he would need to go to America to further his medical career and put his entrepreneurial spirit to good use. Since his country had become locked behind the Iron Curtain, this was not an easy matter. Repeated attempts to visit the West through regular official channels failed. He decided escape was the only possibility, and set about making a plan. He concealed himself under the freight car of a western-bound train. He had concocted and now used a scent made from herbs which would mislead the guard dogs used to patrol the tracks at border checkpoints.

Having eluded the guards, he arrived in Yugoslavia and made arrangements for onward passage to Vienna. It was here that he ran into trouble, as Vienna is truly a city of International spying; an uneasy meeting point between elements of the East and West. Dr. Vesco was spotted and after a dramatic chase, escaped on a plane flight to New York.

Having arrived in the United States in this manner, however, Dr. Vesco was in the unfortunate position of having entered the country illegally, and he came very close to being turned away by the authorities even though he had declared himself immediately. He thereupon spent three months in a high-security Immigration Detention Center while his case was debated. In the end the verdict was positive, and Dr. Vesco was welcomed to the U. S. as a skilled professional who would prove to be a good and valuable member of his new country and community.

Within the space of a year, Dr. Vesco had studied for and successfully passed both the ECFMG exam required for admission to a U. S. Medical residency and the three-day FLEX exam required for medical licensure in the U.S. He is currently completing a residency in Internal Medicine, and has already been fully licensed by the State of Michigan and the State of California.

Upon his arrival in the U.S. Dr. Vesco resumed a long-standing friendship with a leading biochemist from Europe, now a resident of Los Angeles. He and Peter Smith decided to combine talents and start a new cosmetics firm. The founded PSS Research Laboratories in Hollywood to create a line of high quality skin and hair care products, combining the finest in natural ingredients with the latest in scientific and technological

advances in the cosmetics field. They call their line PROSPERA, a token of the freedom and prosperity they have found in their new home in America

Dr. David T. Vesco is currently serving on the staff at St. Joseph Hospital, Pontiac, Michigan.

Dr. Vesco is happy to announce that in November 1986 he became a U. S. Citizen.

Mr. KRAWITZ. Just so I have an idea, after this gentleman speaks is there anyone else? All right, fine, two more individuals.

Your name for the record, please?

STATEMENT OF PAUL MURPHY

Mr. MURPHY. I am Paul Murphy a U.S. Citizen, I live and work in Michigan.

Mr. KRAWITZ. Welcome.

Mr. MURPHY. I thank Senator Riegle, the staff and all the people who are here today for allowing me these few minutes to comment. This is prepared, will take 3 or 4 minutes of what I have to say and is very important. I shall address this as though Senator Riegle were still present because I prepared this and came earlier this morning.

I am here to condemn the Medicare Program and all it stands for. It is wrong and I want no part of it. Neither you, Senator Riegle, nor anyone else in this room is entitled to 1 penny of my income regardless of your needs for medical care, food, shelter, or whatever.

What is more, I am healthy and pay far more than taxes than your services will ever give me back. You may need me, but I don't need you and I want you to leave me and my wallet alone.

In my lifetime, I have seen an enormous change. In my youth I saw the twilight of an era whose banner of freedom and property rights. In my thirties and forties I saw the rise of income taxation and bore witness to this legalized theft which shackled my abilities and looted my efforts.

In recent years I have seen the accelerating destruction of this once great Nation at the hands of your common good morality, your pressure group politics, your mob mentality. So what if a majority of the electorate think they deserve an income tax percentage of my effort, my work and my income. The public didn't earn my money, I did. My money and what bought it, my work, was not created by the wealth of the people or act of Congress, I created it.

My rights are not a gift from God, the Constitution, or society. My rights are not mandated by the laws of this country, by the laws of logic. A thing is what it is and I am a man. My rights derive from my nature as a man.

Man's survival depends upon productive work which requires rational thought, which requires personal freedom which means the banning of force from all social relationships. It is freedom from interference by others which may properly be called rights and consequently there can be no right to interfere with another man's freedom such as his freedom to earn a living. Since earning a living involves acquiring and using property, it is a man's right to keep and trade his property which includes his income and the products of his labor.

A man without property rights is a slave. There can be no right to enslave, not at any time to any degree, in any respect for any purpose; including, supporting the poor, the sick or the aging.

You who holds it's noble to sacrifice the strong to the weak have never understood the virtues of a strong man, among which are ambition and independence. What do you think 50 percent income

taxation does to a man's ambition? What do you think welfare statism does to a man's independence?

How do your propose to help the weak by punishing the strong, by punishing strength? How much longer can your victims, the businessman and laborers of this country, hold on to their vision, integrity, and effort?

When will your income taxation and printing press money finally topple the economy? What will happen when there are no more producers to loot? When you will face the alternative; produce or perish? The answer to the last question is inevitably.

Thank you.

STATEMENT OF JOE ORSAG

Mr. ORSAG. My name is Joe Orsag O-r-s-a-g. Orsag meaning country in Hungarian. I was born on Ferry Street a few blocks from where the poor people live, east side of the river near where the main library was, the island. The heart institute wasn't there yet when I was born in 1913 when mothers gave birth in homes.

A native of Detroit, born on Ferry Street behind Russel at a socialist worker's home two doors away from it where six people were killed in 1932 asking for jobs at the Ford Lush Plant, asking for jobs for food and they were shot down on March 6, 1932. Now, that is the answer my government gave.

Now, I don't want to digress.

Mr. KRAWITZ. I appreciate that.

Mr. ORSAG. The thing is that all things are related really in life; for example, I depend on the experts, the researchers. When others—Dr. Hahn Studley wrote a book, "The stress of life." Anyone who has any human feeling at all, I didn't get my connections here.

I'm here for myself, Joe Orsag. The last names mean ccuntry in Hungarian, but I speak as Slovak languages. They're all interrelated like the Roman's languages. If you know one, you can pick the other ones up.

So, the thing is I'm thankful for most everything and I'm very humble. I've learned from my parents and everyone in life what to do and what not to do. I've learned it and I'm keeping on learning. I've learned to always appreciate the most precious things in life and they are the human values. The life in each one of us, each one, the life is so precious and the mental and physical health and also sincere and true love and all the different levels of human relationships.

Instead of being hypocritical and playing cruel games to love and care for one another. You don't need a marriage license to have love. Marriage licenses have been used to really make it legal prostitution and also legal rip offs to rip off each other. That's what the hell licenses have meant.

But I don't want to digress, the main things is that these human values, without that life is not worth living. Money is a means of exchange and we need the money in order to get the basic essentials of food and shelter and clothing and the medical services that we all need. And the reason, the reason we are lacking in medical services and anyone here with human feelings who resents moves

deeply with compassion for all the suffering that we've heard the different people express here.

I'm sorry, but I am deeply moved and I have always been moved and I cared. I worried about humanity and I will continue to do so. So, I represent really myself, but I am also working with a dear friend of mine, Dr. John Mecartney, coordinator for Nonviolent Action for National Defense Institute, and I am a member of the all Resistors Link. I am looking forward to going to the national convention again in August in Bailey, North Carolina, the hotbed of the Ku Kluxers and fascist. Our motto of our organization is nonviolence means action without hatred, justice without prisoners and revolution without government——

Mr. KRAWITZ. Thank you. Thank you very much.

I want to thank everyone, we do appreciate your coming and again, thank you very much. This meeting is adjourned.

[Whereupon the hearing concluded about 3:15 o'clock p.m.]

[Additional material for the record follows:]

[From the Wall Street Journal, June 1, 1987]

AFTER 5 YEARS, EXPERIMENTAL HEALTH PROJECT FOR MEDICAID RECIPIENTS SHOWS MIXED RESULTS

(By Clare Ansberry)

In Jackson County, Mo., federal Medicaid recipients no longer rush to the hospital emergency room for treatment of common ailments ranging from a head cold to a rash. As a result of an experimental program, each recipient has been assigned a doctor or health clinic and can get medical help 24 hours a day. State officials figure they've saved $2.5 million since 1984 as a result of the program.

However, In Monterey County, Calif., a similar experiment failed miserably in 1985 after the program had millions of dollars of losses because of lax cost controls.

The widely disparate results of these federal projects—two of a half dozen initiated in 1982 and aimed at curbing exploding Medicaid costs while also improving medical care—underscore the difficulties in stemming sky-high health care costs to the poor.

Since its inception two decades ago, the federal program providing health care to the poor has been plagued by escalating costs, which now exceed $42 billion annually. A great deal of that Medicaid bill has reflected inappropriate use of hospitals. The poor, often turned away by doctors who consider Medicaid's reimbursement fees too low for the care they assumed the poor needed, are forced to rely on the nearest health facility. Typically, that's an inner-city hospital where costs are even higher than a doctor's office but where the much-needed continuity of care is lacking.

That situation stimulated the federal Health Care Financing Administration to fund the pilot programs in Missouri and California as well as New York, Minnesota, New Jersey and Florida.

FOLLOWS HMO CONCEPT

Most of the half dozen experiments follow the Health Maintenance Organization concept, in which doctors, health groups, hospitals or HMOs are paid a fixed amount in advance of all treatment; patients are "locked" into one such medical care provider. Under Medicaid, doctors are paid a fee for each service. Furthermore, the states set their prepaid rate at 90% to 95% of the fee-for-service cost, thus guaranteeing a savings.

The demonstration projects are being watched closely since states increasingly are encouraged by Uncle Sam to use prepayments rather than the fee-for-service approach. Indeed, President Reagan's proposed federal 1988 budget seeks to give states a bonus if they pay standard amounts in advance for each Medicaid beneficiary.

But a chief concern about the pilot programs is the quality of care the poor receive. Both state and federal authorities acknowledge that the prepaid system can be abused by providers who collect regular rates but give only cursory care. They have cause for concern; a Rand Corp. study last year found that HMO-style pro-

grams "in general may be predisposed to underserve and the poor may be less likely to overcome this obstacle."

"We know there's a danger," says Ronald Deacon, an official of HCFA's demonstration division, explaining that's the reason the agency has monitoring programs. Among other things, officials of the demonstration projects keep tabs on whether the use of medical specialists for the poor seems unusually low and also attempt to assess whether doctors try to "dump" high risk poor patients on other health-care providers.

In Jackson County, which includes Kansas City, Medicaid recipients long knew only the hospital emergency room; most had no family doctor. Thus, for example, an asthmatic suffering frequent attacks might see one emergency-room physician one visit and another the next. "There was no way to keep track of what medications and treatments had been tried and what worked," says Ronald Meyer of Missouri state Medicaid program.

MEDICAL CARDS LIST

Under the pilot project, a Medicaid recipient's monthly medical cards list the name and telephone number of their doctor or health group. Besides the 24-hour care available, a doctor who can't provide the needed assistance gets authorization to refer the patient to a specialist or to hospitalize the patient. With ongoing care, patients don't get as sick, Mr. Meyer contends.

This feature has been especially beneficial to pregnant Medicaid recipients, many of whom under the traditional program wouldn't see a doctor until their eighth month of pregnancy. And by then, lack of a proper diet and medication might have made them high risk patients and require "two weeks in the hospital at delivery instead of two days," says Mr. Meyer.

In Jackson County, most previous Medicaid providers opted to participate in the pilot project rather than lose a portion of their business. This required them, however, to change their billing and more closely monitor care since they weren't guaranteed payment for each service.

Some health care providers in the program found that some specialists were balking at accepting Medicaid patients referred to them by the providers. The solution to that problem has been quite simple. "You tell a radiologist that if he or she won't take your medicaid patient, you won't send your cash-paying patients there either," says Starks Williams, a Jackson County physician and medical consultant.

As a result, health groups are beginning to market "extras" such as dental care and nutrition counseling to snare a greater share of Medicaid recipients.

The results in Jackson County are considered encouraging. For example, costly inpatient days for the Medicaid population in the program has dropped to 600 from 1,100 for every 1,000 recipients. The state has received permission to make the experiment an ongoing program.

A similarly structured pilot project in Santa Barbara County, Calif., also has proven successful and the state has asked to adopt its model as a continuing program.

A $6 MILLION DEFICIT

However, the Monterey County, Calif., project was dismantled after less than two years because of a $6 million deficit. HFCA's Mr. Deacon blames the Monterey failure on the county's approach: Although Medicaid recipients were "locked" into one care giver, doctors still were paid a separate fee for each service as opposed to one lump sum in advance. In addition, physicians at one point received a monthly $3 case management fee for each Medicaid recipient.

"There was little incentive to control costs," says Mr. Deacon. Indeed, unlike Missouri and Santa Barbara, Monterey County's model didn't require doctors to get any formal authorization for referral care and nonemergency hospitalization. "In hindsight, the county didn't negotiate tough enough with physicians," Mr. Deacon contends.

In Florida, rate-setting was also a problem. In that state, only two of 12 HMOs agreed to participate in the project; the rest claimed rates were too low. As a result, the program has been downscaled to work with only the frail elderly and one hospital. In Monroe County, N.Y., providers also contend rates are too low and have threatened to pull out in July. The providers say that as a group, they had a loss of $2 million in 1986 after payments dropped 12%. There the problem seems to reflect the use of 1984–85 as a base year to set rates. That was a year in which medical costs were untypically low, says James Fatula of Medicap Inc., which administers the demonstration.

Still even in Monroe County, where the future of the program is tenuous at best, providers believe in the concept. "The idea of a prepaid system is much better for everyone," says Richard Greene, president of the Rochester Health Network. "That being the case, it's only a matter of time before everyone does it."

[From the Wall Street Journal, May 29, 1987]

Health Care for the Poor: How To Pay for It

(By William S. Woodside)

Through a combination of private and public health-insurance programs, more than 80% of Americans have at least basic health-insurance coverage. But there are still more than 30 million people—11 million of them children—who have no health insurance whatsoever. When these people get sick, they often receive care—but frequently the care is later or in the highest-cost setting.

We all pay for the medical bills that the uninsured cannot pay—to the tune of more than $7 billion a year. Uncompensated care is now a hodgepodge of hidden subsidies, inflated bills, and redistributed resources in both the private and public insurance systems. In effect, doctors, hospitals and other providers have been expected to serve the medically indigent and to pass along the cost through higher charges to taxpayers, paying patients and insurers.

Never an efficient system, these hidden subsidies are now being rapidly eroded as businesses and private insurers have aggressively tried to lower the soaring cost of health care. Such techniques as preferred provider organizations, utilization reviews, cost-sharing with employees, and tough bargaining with hospitals and doctors are making it nearly impossible for health-care providers to continue to shift the cost of charity cases and bad debts to paying patients and insurers. Government, too, is putting the squeeze on costs as it gains experience with prospective payment under Medicare and other measures.

NEW DIRECT SUBSIDIES

As the hidden "taxes" are eliminated, we should devise new direct subsidies to help the needy. This step is not only humane; it is also vital to preserve and extend the gains from making health-care markets more competitive.

No one in this country should be denied reasonable access to health care because he is too poor to buy insurance on his own. A combination of private and public actions can greatly expand health coverage to many more Americans, while at the same time building more cost discipline into the health-care sector.

More than half of uninsured Americans are full-time, full-year private-sector workers and members of their families. Most do not have health insurance because they work at jobs paying under $10,000 a year for small employers often hard-pressed to offer group health benefits. The extremely high cost of purchasing health insurance on an individual basis makes it virtually impossible for these workers to care for themselves and their families on their own.

Many of the remaining uninsured are the poor who, for various reasons, do not qualify for Medicaid, the state-federal program that provides insurance for certain low-income groups. Today, only about half of the poor are eligible for Medicaid, down from about two-thirds a decade ago.

One reason for this is that most of the poor receive Medicaid through eligibility for Aid to Families with Dependent Children, and the states set their own AFDC requirements.

Therefore, even for some of the very poorest, getting Medicaid health coverage is more an accident of where you live than what your family may need. For example, if the head of a family of four in Alabama has an adjusted income of $1,764 a year—one-sixth of the federal poverty line—the family earns too much to qualify for AFDC and therefore Medicaid. However, the same family could have an adjusted income of as much as $8,808 a year in California and still quality for Medicaid.

Clearly there are gross inequities in the Medicaid system, and major reforms are needed to bring health coverage to the poor who happen to live in the wrong state. But government alone cannot be expected to solve all of the health-care problems of the medically indigent, especially since most of the uninsured are working full time in the private sector.

Many of the working poor could afford health insurance if business groups such as local chambers of commerce and health-care coalitions working with insurance companies could make group policies available to small employers and individuals.

One vehicle is the multiemployer trust. Another approach involves statewide risk pools. Sponsors of these group plans would, of course, need to establish rules that prevent employees entering and leaving the plan according to their own or their dependents' medical conditions.

Employers also could negotiate with hospitals and other medical-care providers to recognize openly that indigent care is a legitimate part of provider overhead. Although no one employer or hospital could reasonably be asked to underwrite such uncompensated care, sharing among a large number of bill-payers could address costs without creating an undue burden. For example, employers could agree to shave one or two points from discounts negotiated with hospitals or groups of doctors. This added payment would be directed toward a pool for uncompensated care.

If employers wish to avoid inflexible government mandates, they must find ways to pool risks and extend basic health-care coverage to more uninsured workers.

While the private sector can do much to bring health benefits to working Americans, major reforms are needed to bring better balance to Medicaid. At a minimum, the federal government should establish a floor on AFDC benefits to ensure that at least the poorest of the poor in every state are eligible for Medicaid. In addition, Medicaid should be extended to cover more people who fall between the threshold for eligibility for welfare cash assistance and the federal poverty line.

The long-term solution to providing health care for the poor, however, should involve separating government aid for health care from welfare entirely. This can be done by moving toward a program of refundable tax credits that would allow the poor to purchase private insurance on their own. In effect, this program would replace the current Medicaid system with one that issues the poor and near-poor specially earmarked subsidies geared to the cost of basic health insurance in their areas. This could be accomplished either through refundable tax credits or a sliding-scale voucher approach.

Giving the poor and near-poor a fixed-dollar cash subsidy to buy a pre-approved health-insurance plan will not only bring greater market discipline to health care but also, for the first time, allow many of the poor access to mainstream American medical care that so many of us take for granted.

How will we pay for all this? When leaders in community business groups and health coalitions debate the cost of devising ways to offer group insurance to small employers and individuals, they would do well to recognize that they already pay a large portion of the cost of uncompensated care in their communities. Greater use of market incentives will pave the way for more equitable and cost-sensitive health care. Part of these cost savings can and should be used to finance indigent care.

There is no denying that bringing more of the poor into Medicaid will cost money. A 1985 congressional study estimated the first-year cost of one proposal to mandate a minimum cash-assistance benefit level and extend eligibility for AFDC and Medicaid at a little more than $5 billion.

POLITICAL WILL IS REQUIRED

Whatever the eventual cost, Medicaid reform must be fully funded. It would be a mistake to rely on additions to the federal deficit to underwrite new commitments to those in need. There are means at the federal government's disposal to fund these commitments, but it requires greater leadership and stronger political will.

For example, more Social Security and some Medicare benefits could be included in taxable income. To share the government's financing burden with the working population, a portion of employee health-insurance benefits (now tax-free) could be taxed. Other options include excise taxes on alcohol and cigarettes combined with cutbacks in other government programs.

Far too often, debates on health care focus on lowering costs—at all cost. While cost containment is an essential goal, health-care dollars should be seen as an investment that will, if wisely spent, ensure a healthy and productive society.

Competition, cost containment and compassion can go hand in hand in reshaping our nation's health-insurance systems. It is up to private and public leadership in this country to see that they do.

(Mr. Woodside, chairman of the executive committee of Primerica Corp., chaired the panel that prepared a health-care study for the Committee for Economic Development, a group of 225 business and education leaders.)

AARP

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

on

EXPANDING MEDICARE TO INCLUDE CATASTROPHIC COVERAGE

before the

THE HONORABLE DONALD W. REIGLE

Member, Senate Finance and Budget Committees

Warren Michigan
June 1, 1987

Presented by:

Clarice Jones

American Association of Retired Persons 1909 K Street, N.W., Washington, D.C. 20049 (202) 872-4700

John T. Denning, *President* Cyril F. Brickfield, *Executive Director*

EXECUTIVE SUMMARY

* The most critical catastrophic expense of older Americans is long-term care. Nursing home stays account for 80% of the expenses incurred by the elderly who have very high out-of-pocket medical costs. The current Medicare program provides little relief from these expenses.

* Medicare's coverage of acute catastrophic care is seriously deficient. Beneficiaries must pay deductibles and coinsurance for Medicare-covered services, and must bear the full weight of the cost of non-covered services. 21% of all Medicare beneficiaries have no supplemental or Medigap policy to cover any of these expenses.

* Medicaid offers little protection against catastrophic costs. In 1986, only 26% of elderly people with family incomes under $5000 were covered by Medicaid.

* The Administration's catastrophic proposal, while an important first step, offers minimal protection against acute care costs and no protection against long term care costs.

* S. 1127, approved by the Senate Finance Committee last week, improves on the Administration's proposal by lowering the cap on out-of-pocket expenses and offering greater

  benefits bridging the gap between acute care and long term care.

* AARP advocates the creation of a catastrophic plan that is more comprehensive than either the Administration's or the current Senate Finance Committee plan and one that would balance the need for acute care protections with the need for long-term care protections for all beneficiaries, including those with low incomes.

* AARP recommends that S. 1127 be amended to include a prescription drug benefit, a respite care provision and to provide for <u>both</u> protections against impoverishment of nursing home residents' spouses <u>and</u> a requirement that Medicaid pay the premiums to enable low income persons to receive the catastrophic coverage.

* To finance these improvements, AARP urges that the Congress consider doubling the tobacco tax; expanding Medicare coverage to state and local workers; and modestly increasing the Part B premium.

Thank you, Senator Reigle. On behalf of the 25 million members of the American Association of Retired Persons, I wish to thank you for this opportunity to state the Association's views on the problem of catastrophic illness.

Before I begin, however, I would like to say that the Association is gratified by the current congressional and public interest in the problem of high cost illness and its impact on the citizens of this country. We believe that the public debate on catastrophic illness will lead to a more complete and more accurate understanding of the problem; the debate itself is, in our view, a critical step in the development of workable, appropriate solutions to a complex but hardly intractable social problem.

The Association commends Senator Reigle and the members of the Senate Finance Committee for their work towards the development of catastrophic health protection for the American public.

I will focus my remarks this morning on four areas: the major source of catastrophic costs for older Americans; the nature of the acute care catastrophic experience among older Americans; proposals to address elements of the catastrophic problem; and finally, recommendations by the Association, building in part upon the work of Secretary Bowen, and the Senate Finance Committee.

THE MAJOR SOURCE OF CATASTROPHIC COSTS FOR OLDER AMERICANS

Let us be clear this morning about the source of catastrophic costs for this country's senior citizens. Indisputably, the most critical need for catastrophic protection for older Americans is for help with the costs of long-term, chronic illness. As Chart 1 indicates, nursing home stays account for over 80% of the expenses incurred by older people who experience very high out-of-pocket costs for health care (over $2,000 per year).

The need for long-term care leads almost inevitably to an unmanageable financial burden because the costs of care--be it in an institution or in the home--are often enormous. Chart 2 shows the amount that an individual would pay for a 12-month stay in a nursing home and for modest medical expenses during that year. At more than $20,000 each year, few families could survive such expenses without severe financial hardship. Medicare and private insurance combined pay only a miniscule proportion of nursing home costs (less than 3% in 1985). More than half of nursing home costs are paid out of the pockets of residents or their families. Most of the remaining costs are paid under Medicaid, a means-tested welfare program. To qualify for Medicaid, one must either be poor or reduced to poverty in the process of trying to pay for care.

Few people can afford the expense of an extended nursing home stay, so many eventually end up on Medicaid, but only after

financial catastrophe has occurred. Fully one-half of Medicaid dollars for nursing home care is spent on behalf of persons who enter nursing homes as private paying residents. The process of "spending-down" one's income and depleting one's assets to qualify for Medicaid can occur very quickly. A 1985 study conducted for the House Aging Committee found that approximately 2/3 of single older persons and 1/3 of older couples in Massachusetts were impoverished after only 13 weeks in a nursing home.

As such statistics indicate, the impoverishment of a spouse in the community in order to finance the care of an institutionalized mate is one of the most serious problems facing older couples today. To be eligible for Medicaid, couples must often spend-down their combined income and assets, leaving one spouse--usually the wife--destitute. Many of the same women who are caught in the spend-down problem have spent years taking care of ill and disabled husbands at home.

Only a small percentage of long-term care is provided by institutions. The vast majority--nearly 75%--is provided in the community or home. Caregivers, who must often provide round-the-clock attention to disabled individuals, make both emotional and financial sacrifices to meet that need. Brief periods of respite sustain the caregivers in this difficult situation and make it possible for them to continue to provide

care in the home.

Personal care services of indefinite duration in the home are not covered at all by Medicare, and the amount and type of home care provided under Medicaid is extremely limited in most states. Even those who can afford to pay for home health and other in-home services face often insurmountable barriers in locating competent, trained personnel. As a result of both limited access to home care and the very high expense of nursing home care, many older persons live in fear of becoming a burden on their families, or being forced to enter a nursing home and spend their lifetime savings in order to pay for care.

THE ACUTE CARE CATASTROPHIC EXPERIENCE AMONG OLDER AMERICANS

For older Americans who have Medicare coverage, an acute care illness is less likely to result in a catastrophic burden than a long-term illness. But Medicare's coverage of acute care is by no means without significant gaps, gaps which if not supplemented by other forms of insurance, leave individuals vulnerable to devastating medical costs. Chart 2 shows that a Medicare beneficiary with two hospital stays would, on average, incur out-of-pocket expenses that would total nearly $3000 without private supplemental insurance and would even result in expenses over $1600 with an average insurance policy.

Medicare beneficiaries' liability for acute care medical costs consists of two components: (1) Medicare cost-sharing requirements (i.e., deductibles and coinsurance) for covered services, and (2) expenditures for non-covered medical services and goods. It is important to distinguish between these two categories of liability since most of the catastrophic "cap" plans that have been proposed permit the former (coinsurance and deductible amounts) to be counted toward the cap but exclude the latter (expenditures for non-covered services and goods). And the second category of liability is by no means insignificant; we estimate that, on average, for every $1.00 beneficiaries incur in coinsurance and deductibles, they spend an additional $.50 to $1.00 for non-covered services and goods.

1. Deductible and Coinsurance Liability

Under Medicare Part A, beneficiaries are required to pay a hospital deductible in each benefit period approximately equal to the cost of one day of hospital care ($520 in 1987). They are also responsible for coinsurance for days 61 through 90 equal to one-fourth of the hospital deductible. For each lifetime reserve

day (days 91 through 150), beneficiaries are required to pay an amount equal to one-half the Part A deductible, or $260 per day in 1987. While there is no deductible for skilled nursing

facility (SNF) services, Medicare beneficiaries this year will pay $65 per day to satisfy coinsurance requirements for days 21 through 100 in a SNF.

Approximately 23% of Medicare enrollees are admitted to a hospital at least once in a given year. But only about .5% of Medicare enrollees (158,000 in 1984) use more than 60 hospital days in a year, thereby triggering hospital coinsurance requirements.

In 1985, Medicare beneficiaries incurred $3.2 billion in Medicare hospital deductible and coinsurance liability. This amount represented an increase in such aggregate liability of more than 100% between 1980 and 1985. The largest portion of total Part A cost-sharing liability is attributable to the Part A hospital deductible.

Beneficiaries also share heavily in the cost of Medicare Part B services. Each beneficiary must meet a $75 annual Part B deductible, and is also responsible for 20% of the amount that Medicare deems "reasonable" for a particular Part B service. (In addition, beneficiaries whose doctors do not accept assignment

are fully responsible for the amount their doctor charges above the Medicare-approved rate.)

Cost-sharing requirements under Medicare Part B represent a far greater financial burden on Medicare beneficiaries than do cost-sharing requirements under Part A. In 1986, Medicare beneficiaries incurred $5.7 billion dollars in Part B coinsurance liability and $1.7 billion dollars in Part B deductible liability. The most striking rate of increase in physician-related liability has occurred in coinsurance liability which in the aggregate has risen by 170% since 1980. Moreover, increases in Part B coinsurance expenditures have far outpaced increases in Social Security benefits.

Whereas only about one-fourth of Medicare beneficiaries will incur liability from the use of hospital services in a given year, 80% will incur liability from the use of physician services during the same period. Further only .5% of beneficiaries will trigger hospital coinsurance costs, but fully 60% of beneficiaries will incur coinsurance liability for physician services.

Balance billing for physician services remains a serious problem for Medicare beneficiaries. Beneficiaries are protected from balance billing only if the physician they use is a participating

physician or agrees to accept assignment for that particular claim. In 1984, 64 percent of the aged Medicare beneficiaries receiving a reimbursement for a Part B service experienced a

a charge reduction on an unassigned claim. In 1986 charge reductions amounted to $2.8 billion.

While the Association is pleased that the number of participating physicians is increasing and continues to support the program, differences in participating rates geographically and by medical specialty still poses problems for beneficiaries trying to limit their liability for physician services.

2. Medical Services Not Covered by Medicare

In addition to Medicare's cost-sharing requirements for covered services, beneficiaries also face significant out-of-pocket costs for those acute care medical services and goods which Medicare does not cover or which, in the case of certain services, are subject to Medicare's durational limits.

These acute care services include:

- Outpatient prescription drugs
- Balance billing by physicians on non-assigned claims
- Dental services/products
- Optical services/products
- Hearing care services/products
- Routine physician examinations, influenza shots, Pap smears.

out-of-pocket expenditures for these non-covered acute care services can be staggering: almost $3 billion for balance billing by physicians; more than $2.3 billion for dental care; and more than $1.4 billion for eye care.

3. Medigap's Role in Protecting Beneficiaries Against Catastrophic Cost

The gaps in Medicare's coverage, particularly its cost-sharing requirements, have led to the development of private supplemental insurance plans, so-called "Medigap" policies. About 70% of Medicare beneficiaries are covered by such plans. Since the enactment of the Baucus amendment in 1980, Medigap plans are required to cover: (1) hospital coinsurance; (2) 90% of Part A expenses after exhaustion of the lifetime reserve to a lifetime limit of 365 additional days; and (3) the 20% coinsurance on Medicare Part B services. Such plans are not required to cover either the hospital or physician service deductible, although most offer coverage of the former. Finally, the plans may impose their own deductible of up to $200 per year for Part B coverage.

In spite of the Baucus amendment, there is great variability in the depth and scope of coverage provided by Medigap plans. Most Medigap plans provide little or no coverage of prescription drugs, balance billing by physicians, dental services, and

extended nursing home care. Moverover, the Baucus amendment does not apply to employment and labor organization-related group insurance, conversions from group plans to individual policies, and policies in effect before July 1, 1982. Finally, some plans may be very costly relative to the benefit returned to the insured.

It should be noted that supplemental coverage through a Medigap plan is positively correlated with income and education. Yet almost half of elderly people with less than $5000 per year in family income purchase Medigap plans (see chart 3). Even if the coverage selected is modest, the premium payments for such plans must constitute a terrible drain on already meager resources.

Let me at this point clarify the Association's position on the ability of the private insurance industry to protect older Americans from the inadequacies of Medicare's coverage. The Association offers its members a Medicare supplemental insurance plan that fills many of the existing gaps in Medicare coverage. We believe, however, that filling such gaps through the Medicare program is inherently the most efficient way to insure against acute care catastrophic costs. Accordingly, we welcome any meaningful improvements in the Medicare program that will reduce the need for supplemental insurance plans or make them unnecessary.

4. Medicaid's Role in Protecting Beneficiaries Against Acute Care Catastrophic Costs

It is reassuring to believe that the Medicaid program serves to protect elderly beneficiaries from potentially catastrophic acute care out-of-pocket expenditures. But this is not necessarily the case. The Congressional Budget Office (CBO) reports that in 1986 only 27% of elderly people with family incomes below $5000 were covered by Medicaid (see chart 3). How can this be? We have only to look to the variability in Medicaid's eligibility requirements across states for an answer. There exists no national mandatory income standard for Medicaid eligibility, no mandated coverage of the "medically needy", and no uniformity in eligibility for a Medicaid "buy-in" of Medicare Part B coverage.

5. The Vulnerable Elderly

Who among the elderly are most vulnerable to acute care catastrophic costs? Surely the answer must include those who are not able to afford Medigap coverage, but who also do not qualify for Medicaid coverage. Such individuals tend to be frail, low-income, and uniquely vulnerable to the cumulative financial burden resulting from Medicare coinsurance and deductibles and from the costs of all non-covered services and goods. For nearly 21% of the elderly, Medicare represents the only source of protection (see chart 4).

A second group worthy of particular concern includes the poor/near poor who feel compelled to buy Medigap insurance but who can ill afford it. One can only surmize that such individuals must forego certain day-to-day essentials in order to purchase such protection (see chart 3).

THE ADMINISTRATION PROPOSAL

The Association is encouraged by the demonstrated interest of the Administration and the Congress in finding solutions to the problem of high cost illness for older Americans, although we are disappointd over the almost exclusive preoccupation with costs arising from acute care illness. The Administration proposal based on earlier recommendations of Secretary Bowen addresses only acute care costs, providing beneficiaries with unlimited hospital coverage subject to two deductibles each year and "capping" annual out-of-pocket expenditures for Medicare coinsurance and deductibles at $2000.

The Association recognizes that, through his recommendations to stengthen the Medicare program, Secretry Bowen took an important first step in the development of a viable plan to protect beneficiaries against acute care catastrophic costs. Nevertheless, it must also be recognized that the Secretary's catastrophic proposal--now the Administration's catastrophic

proposal--is a minimal one. The $2000 cap on coinsurance and deductibles would hardly protect an elderly person of limited or even moderate means from financial catastrophe. Nor is it likely to persuade Medigap holders to drop their supplemental plans and self-insure for the first $2000 in coinsurance and deductibles.

Further, under the Administration plan, no out-of-pocket cost for the following services and products would count toward the annual cap: long-term nursing home care, out-patient prescription drugs, dental services, home health services, respite care, physical examinations, balance billing by "non-assigned" physicians, and optical supplies and services. The Administration plan may thus offer some improvement in Medicare's coverage, but it is misleading to suggest that it would provide older Americans with protection against catastrophic health care costs.

THE SENATE FINANCE COMMITTEE BILL

Last week the Senate Finance Committee approved a catastrophic coverage bill which incorporates many of the recommendations in AARP's proposal. The bill removes hospital day limitations and limits inpatient cost-sharing to one hospital deductible per year. It improves the home care benefit and reduces skilled nursing facility coinsurance while extending

that benefit. The bill provides a combined Parts A and B cap of $1700 per year as contrasted with AARP's recommended Part B only cap of $1000. The bill does include low-income protections by allowing states to purchase Medicare coverage for Medicaid beneficiaries, but the coverage is not required. Instead, states are given the option to choose either the Medicaid buy-in or protections against impoverishment of spouses of nursing home residents. There is no respite care benefit and there is no drug benefit, although the committee has indicated its intent to develop one.

The package is financed by a two-premium system. The first premium is a flat $4.00 per month added to the Part B premium. The second, or supplemental premium is based on the income tax liability of the beneficiary and is collected through the tax system.

AARP believes that the proposed Finance Committee bill includes some valuable protections for Medicare beneficiaries. It is also missing some important elements. It does not have a meaningful prescription drug component, it includes no respite care provision, and it forces an unacceptable choice of either providing catastrophic coverage to Medicaid beneficiaries or protecting persons from impoverishment when their spouses are institutionalized in nursing homes.

In order to have a catastrophic protection law that offers meaningful protections to a majority of Medicare and Medicaid beneficiaries, AARP urges that at a minimum S. 1127 be amended as follows: 1. Provide a prescription drug benefit that covers all

medications, not just immunosuppressants, which benefit few. A benefit with a $400 deductible will provide relief to the majority of older persons who expend large sums on life sustaining medications to control chronic conditions of aging.

2. Include a respite care provision, to provide the temporary relief which enables family caregivers to continue providing care in the home to persons who would otherwise be institutionalized.
3. The bill must not pit protections for spouses against coverage for low income beneficiaries. Both are essential components of catastrophic coverage targeted at different but equally needy populations. A humane catastrophic bill must include both protections.

Finally, we must say a word about the proposed method of financing. Although we find this two-tiered premium system less onerous than alternative proposals to tax the actuarial value of Medicare coverage,it is not AARP's preferred financing mechanism. We encourage Congress to seriously consider AARP's financing proposal. Including all state and local employees in Medicare

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and increasing the tobacco tax are both equitable options which would contribute substantially to the financing of catastrophic benefits. If these options were taken, along with a minimal flat premium on all beneficiaries, there would be no need to move into the uncharted territory of supplemental premiums.

AARP'S CATASTROPHIC PACKAGE RECOMMENDATIONS

One of the dilemmas policymakers face in attempting to set a protective "cap" on catastrophic costs is pinpointing the appropriate level for such a cap. Set the cap [illegible], and the benefit can be financed without great difficulty; but as is clear from chart 5, few are protected under such an arrangement. As one pushes the cap down, the protective scope of the cap expands but the cost rises proportionately. Severely restrict the elements of liability which count toward the cap, and the plan becomes more affordable; the danger in <u>this</u> arrangement, of course, is that beneficiaries may wrongly assume that their <u>total out-of-pocket liability</u> in a given year will not exceed the cap level. As they gradually come to realize that a full range of essential medical services and products do not even count toward the "catastrophic" cap, they are apt to feel disappointed, if not duped. It is important, then, that any plan that lays claim to

providing any level of catastrophic protection must identify and appropriately address actual sources of vulnerability. The Association believes that long-term care is the real source of catastrophic costs for older Americans, including middle-income older Americans. We also believe that while acute care costs--for both coinsurance and deductibles as well as non-covered services and goods including prescription drugs-- can threaten the financial security of many older Americans, they are potentially devastating to low-income elderly.

Given these concerns, the Association advocates the development of a benefit improvement that incorporates a catastrophic cap but is more comprehensive than the Administration plan or the Finance plan and that, in our opinion, better balances the need for acute care catastrophic protections with the need for long-term care catastrophic protections. It also includes critical protections for low-income Medicare beneficiaries.

We do not delude ourselves in advancing the following set of recommendations that we have solved the catastrophic problem for older Americans. We do believe that in many respects our proposals expand, refine, and improve upon the efforts of others who have also grappled with this complex issue. Our proposals represent an earnest attempt to fulfill the President's pledge to protect Americans against catastrophic health care costs.

The benefit structure of the Association's package can be divided into three pieces:

1. Acute Care
2. Transitional Care
3. Long-term Care

Under the acute care component, we propose the following:

- o One hospital deductible per year;
- o Elimination of hospital coinsurance;
- o Elimination of lifetime limits on hospital care;
- o A $1000 cap on Medicare Part B cost-sharing (i.e., deductibles and coinsurance);
- o A prescription drug benefit with a $400 annual deductible and a minimal or no copayment on each filled prescription;
- o Improvement in the Medicaid program through the expansion of coverage through a Medicaid "buy-in" to Medicare for individuals below 100% of the poverty level, expansion of "medically needy" coverage and establishment of uniform mandatory income.

  We view this element of the package as inseparable from the cap which, at $1000, is too high to adequately protect low-income

beneficiaries.

Under the transitional care component, we recommend:

- o Elimination of SNF coinsurance;
- o Elimination of the three-day prior hospitalization requirement for SNF eligibility;
- o An expanded home health care benefit;
- o A respite benefit to provide assistance to caregivers.

Our long-term care component would include:

- o Protection against spousal impoverishment;
- o Expansion of home and community-based waiver services.

The Association recognizes that, given a burgeoning federal deficit, the kind of improved benefit package we are recommending must be self-financed. Further, results of a recent AARP survey indicate a willingness among a majority of older people to pay increased premiums in return for significantly expanded benefits. Nevertheless, the full burden of the costs of the improved package we are advocating should not fall exclusively upon the elderly. To pay for the improvements we have described above, we propose using several financing sources, some targeted on improvements in the Medicare program and others targeted on Medicaid remedies. These potential revenue sources include:

- o doubling of the tobacco tax (targeted to Medicaid);

- o extension of HI coverage to state and local employees; and
- o an increase in the premium

The package we have proposed,like those proposed by the Administration and the Finance Committee would probably not represent a replacement for a typical Medigap plan. We believe, however, that responsible private insurers would respond with a corresponding offset (i.e., reduction) in Medigap premiums to match their reduction in risk exposure. Thus, the net additional cost in premiums to the 70% of Medicare beneficiaries carrying supplemental insurance could be minimal. As a complementary measure, our recommended Medicaid improvements would serve to protect those not currently covered by Medigap or Medicaid.

CONCLUSION

I would like to conclude my remarks this morning with two observations. First, we focus our attention here today on the plight of older Americans, many of whom struggle daily under the crushing weight of catastrophic medical costs. Initial action to address their plight is appropriate and, indeed, long overdue. But let us not forget the suffering of some 37 million Americans under the age of 65 who have neither public nor private health insurance and the 15 million who do not have adequate

coverage. Surely a nation as richly blessed as ours in material wealth, wisdom, and compassion can summon the resolve to correct this terrible and intolerable social wrong. For our part, we cannot in good conscience support filling the "gaps" in Medicare's coverage, while at the same time ignoring inadequacies in health insurance coverage for working Americans and our nation's children.

Finally, as we convene this morning, we do so with the realization that Congress is poised for action on catastrophic protections for older Americans. Whatever the outcome of this year's initiative on catastrophic illness, let us be scrupulously correct in characterizing to the American public what we have accomplished and, perhaps more importantly, what we have <u>not</u> accomplished in our efforts to come to grips with one of this country's most pressing social needs.

CHART 1

OUT-OF-POCKET COSTS BY TYPE OF SERVICE (1980)

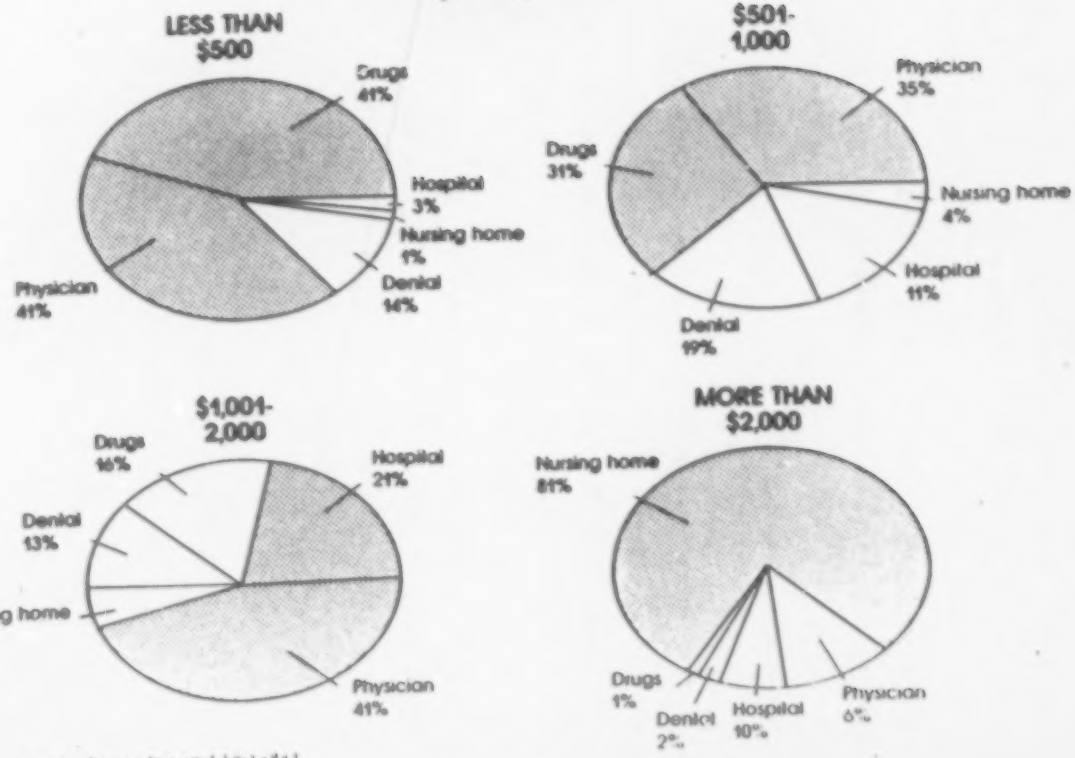
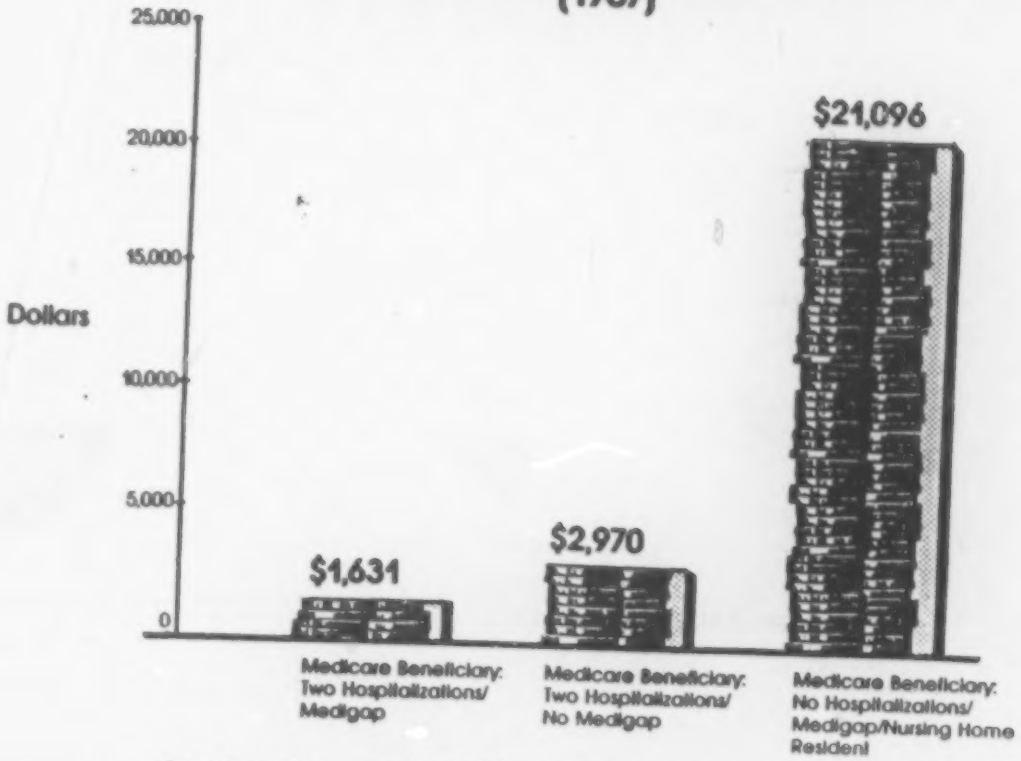


CHART 2

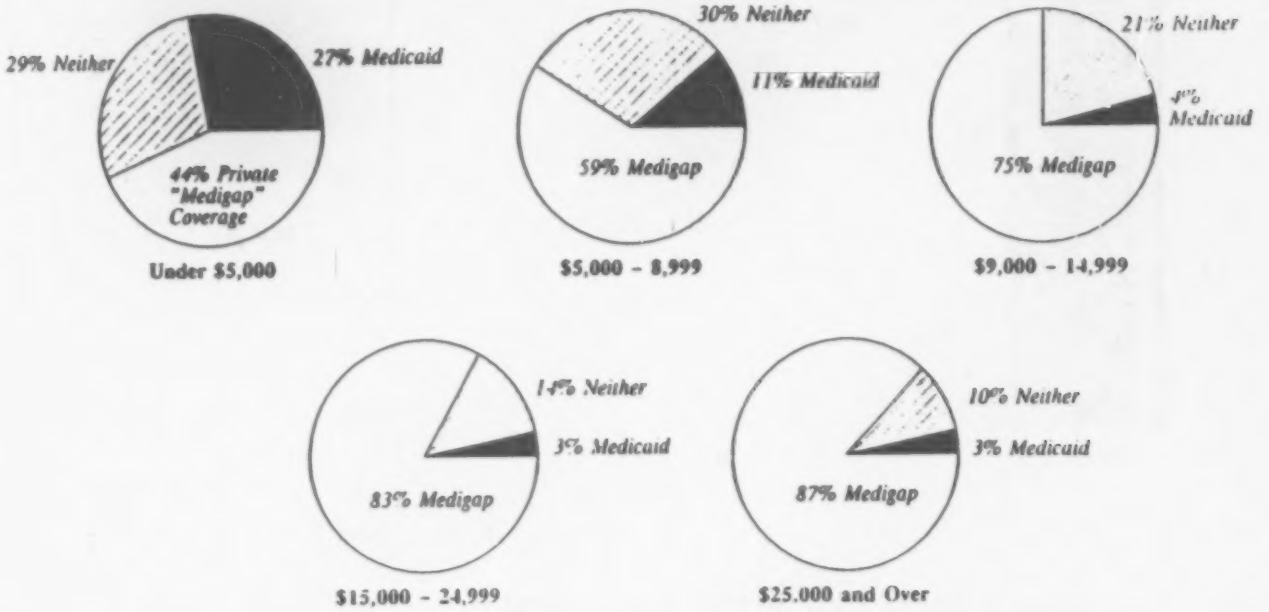
ANNUAL OUT-OF-POCKET MEDICAL EXPENSES FOR THREE MEDICARE BENEFICIARIES (1987)



Source: Based on Congressional Budget Office preliminary estimates

CHART 3

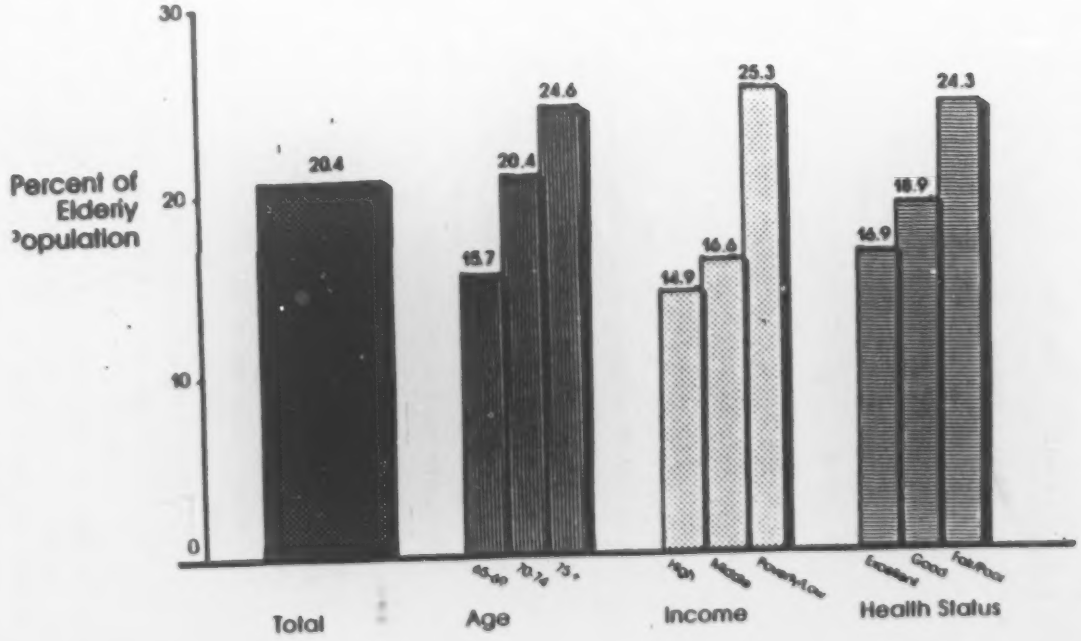
MEDIGAP COVERAGE FOR THE ELDERLY POPULATION BY FAMILY INCOME, 1986



Source: Congressional Budget Office.

CHART 4

ELDERLY POPULATION WITHOUT PRIVATE HEALTH INSURANCE OR MEDICAID



Source: National Center for Health Services Research

A.D.™ Alzheimer's Disease
and Related Disorders Association, Inc.
17251 W. Twelve Mile Road • Suite 103 • Southfield, Michigan 48076 (313) 557-8277

Testimony
for Senator Donald W. Riegle, Jr.
Senate Hearing on Health Care Issues
June 1, 1987

My name is Pat Johnson, I live in Ferndale, Michigan and serve as Family Services Coordinator for Alzheimer's Disease and Related Disorders Association, Detroit Area Chapter. I coordinate the 30 family support groups in Wayne, Oakland, Macomb and St. Clair counties. I frequently visit these groups and am familiar with the concerns of family members. My mother suffered from Alzheimer's disease and died in 1985. One of my primary concerns during her illness was whether her assets would be depleted before she died. She required nursing home care for the last year of her life, but I did not know at that time how long she would live after her admission to the nursing home.

Alzheimer's disease places an enormous drain on a family's financial resources. Patients afflicted with this disease eventually need 24 hour care and usually need to be placed in a nursing home in the later stages. Families often care for the person for years in the home - sometimes to the point of physical and emotional exhaustion. In addition, financial resources may be completely exhausted.

Long-term care, which includes adult day care, respite care, home health care and nursing home care, is one of our primary concerns. Paying for these services "out of pocket" is prohibitive for many families, especially on a long-term basis. Medicare and Medicaid cover only a small percentage of long-term care expenses. Medicare reimbursement for nursing home care is only about 2% of total nursing home expenses; Medicaid reimbursement is about 45%, but is

only available after "spending down" one's assets. Medicare does not help families of Alzheimer's patients to pay for services needed to keep the patient at home.

We are urging the following improvements in Medicare and Medicaid in any catastrophic proposals: a change in Medicaid policy to prevent spousal impoverishment by providing a decent standard of living for spouses of Medicaid patients in nursing homes; expansion of home care services under Medicare; and an increase in the meager Personal Needs Allowance for nursing home residents.

We appreciate your efforts on behalf of persons with catastrophic illnesses and their families.

Statement of the American Medical Association

to the

Subcommittee on Health
Committee on Ways and Means
United States House of Representatives

Presented by

Jerald R. Schenken, M.D.

RE: Catastrophic Coverage for Health and Long-Term Care Needs

March 10, 1987

American Medical Association
535 N. Dearborn Street
Chicago, Illinois 60610

Department of Federal Legislation
Division of Legislative Activities
(312) 645-4775

PRINCIPAL POINTS

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

March 10, 1987

- The AMA advocates that catastrophic health care coverage should be included as part of a package of minimum benefits in all health insurance plans. Such catastrophic coverage can often be provided at relatively small additional cost.

- The AMA has developed a fiscally sound program for financing health care services for the elderly that will assure services to beneficiaries well into the 21st century. Our proposal would provide comprehensive protection, including catastrophic coverage.

- While we support the intent of proposals by Secretary Bowen and others to expand Medicare to provide catastrophic coverage, we believe that such coverage could be provided more efficiently and effectively through private insurance rather than under a government program.

- Before federal action is undertaken, the private sector should be afforded the opportunity to provide the benefits proposed by Secretary Bowen at a comparable cost. Private insurance coverage should also be available that expands upon and broadens Medicare benefits.

- Innovative approaches should be explored for providing catastrophic protection for the elderly who have neither Medigap nor Medicaid coverage. For example, vouchers could be provided to such persons to help them pay the premiums for private Medigap policies that include catastrophic protection. Alternatively, Medicaid's "spend down" provisions could be liberalized to allow these persons to become eligible for Medicaid after they incur a specified amount of out-of-pocket costs.

- If Congress decides to provide catastrophic coverage through an expansion of the Medicare program, such coverage should be limited to acute health care costs and should provide some form of means-testing.

- Broad personal and family responsibility for long term custodial care expenses should be encouraged through appropriate tax and savings incentives.

- o Adequate health insurance, including catastrophic coverage, should be furnished in the employment setting. Catastrophic coverage can and should be encouraged by limiting the tax deductibility of employer health insurance premiums only to employers who furnish health plans that provide catastrophic coverage and to employers who participate in a statewide risk pooling program.

- o Workers who are laid off should have the opportunity to maintain employment-based health insurance for at least several months after their termination if they continue to pay the same portion of the insurance premium they paid while employed.

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STATEMENT

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AMERICAN MEDICAL ASSOCIATION

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RE: Catastrophic Coverage for Health and Long-Term Care Needs

March 10, 1987

Mr. Chairman and Members of the Committee:

My name is Jerald R. Schenken, M.D. I am a physician in the practice of pathology in Omaha, Nebraska, and am a member of the Board of Trustees of the American Medical Association. Accompanying me is Ross Rubin, Director of the AMA's Department of Federal Legislation.

The AMA is pleased to have this opportunity to testify concerning the important issue of catastrophic coverage for health and long-term care needs. For many years, we have advocated that catastrophic health care coverage should be included as part of a package of minimum benefits in all health insurance plans. Such catastrophic coverage can often be provided at relatively small additional cost. In addition, even though the vast majority of persons would never actually use the catastrophic benefit, its mere existence would provide vital piece of mind.

Mr. Chairman, in discussing catastrophic coverage, it is important to keep in mind that what constitutes a catastrophic expense varies from person to person -- based on individual financial resources. An expense that clearly would be catastrophic to a person relying solely on Social Security cash benefits might be manageable for an individual with a substantial annual income.

Catastrophic care expenses can be divided into two categories: acute health care costs and long-term custodial care costs. Effective steps should be taken now to assure all our citizens, including Medicare beneficiaries, that they will not become impoverished if faced with large acute health care expenses. Efforts should also be increased towards developing mechanisms to cover the potentially catastrophic expense of long-term care.

Acute Care Catastrophic Costs for the Elderly

AMA Proposal

Ideally, the addition of catastrophic coverage to current Medicare benefits should be accomplished as part of a broad reform of the Medicare program to assure its continuation. With this in mind, we have developed a new program, one that is fiscally sound and will assure health care services for the elderly well into the 21st century. Our proposal would provide comprehensive protection, including catastrophic coverage. A summary and a full copy of our proposal are attached to this statement as an appendix.

Advantages of Private Insurance

The AMA recognizes that the catastrophic coverage issue is being addressed by Congress prior to long-term reform of the Medicare program

because of appropriate concern for the risk of catastrophic expense faced by the elderly. While we support the intent of proposals by Secretary Bowen and others to expand Medicare to provide catastrophic coverage, we believe that such coverage is better provided through private insurance rather than under a government program.

The AMA believes that catastrophic coverage could be provided more efficiently and effectively by the private sector. Currently, about 70% of Medicare beneficiaries have Medigap policies. These policies already provide a considerable degree of catastrophic protection because they must meet the following minimum standards as a result of Congressional mandate:

- coverage of Part A inpatient coinsurance for Medicare eligible expenses from the 61st through 90th day of hospitalization in any "spell of illness";
- coverage of Part A inpatient coinsurance for Medicare eligible expenses incurred during use of Medicare's lifetime reserve days (91st through 150th day of hospitalization);
- upon exhaustion of all Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 90% of all Medicare Part A eligible expenses for a lifetime maximum of up to 365 days; and
- coverage of Medicare Part B coinsurance up to at least $5,000 per year, subject to a maximum annual out-of-pocket deductible of $200.

We recognize, however, that gaps in Medigap coverage do remain. For example, the minimum standards for Medigap policies do not require that Part A coinsurance for the 21st through the 100th day of skilled nursing facility care be covered or that such policies provide coverage beyond the 100th day of a stay. We believe that before federal action is undertaken, however, the private sector should be afforded the opportunity to close these coverage gaps and provide the benefits

proposed by Secretary Bowen at a comparable cost. While some companies offer broad coverage, Congress could modify the minimum standards for all Medigap policies to require that meaningful catastrophic coverage be included.

Private insurance companies should also voluntarily expand upon and broaden Medicare benefits. For example, increased coverage could be provided for expanded skilled nursing services, beyond the restrictive Medicare qualifications and even include intermediate care nursing services. Other types of coverage beyond Medicare's strict coverage and reimbursement limits should also be offered.

Coverage for Indigent Elderly

Currently, about 20% of the elderly have neither Medigap nor Medicaid coverage. Most of these persons are poor or near-poor, but are not eligible for Medicaid. Innovative approaches should be explored for providing catastrophic protection for these persons. For example, vouchers could be provided to such persons to help them pay the premiums for private Medigap policies that include catastrophic protection. Alternatively, Medicaid's "spend down" provisions could be liberalized to allow these persons to become eligible for Medicaid after they incur a specified amount of out-of-pocket costs.

In any event, in order to provide coverage for this group, some financial assistance is necessary.

Imposing an additional Part B premium may force some beneficiaries out of the Part B program, exposing this vulnerable population to increased risk. It would be more equitable to provide assistance through a means-tested combined catastrophic and basic Part B premium.

Government-Funded Program

If Congress decides to provide catastrophic coverage through an expansion of the Medicare program, such coverage should be limited to acute health care costs. Otherwise the program would become much too costly. In addition, any government-funded catastrophic coverage program should provide some form of means-testing.

Mr. Chairman, we would like to take this opportunity to compliment you and Mr. Gradison on your proposal which appropriately reflects the need for improved skilled nursing coverage under Medicare and, through the taxing of a portion of the actuarial value of Part A and B benefits, would adopt the concept of means-testing.

Long-Term Care Catastrophic Expenses for the Elderly

The great area of uncertainty concerning catastrophic insurance is the extent, if any, to which such coverage should include long-term custodial care. The average cost of nursing home care is about $22,000 per year. As a result, such care often generates catastrophic expenses. As noted above, we do not favor inclusion of coverage for custodial services in a government-funded health program. We are particularly concerned that the 60% to 80% of the long-term care now provided to the disabled elderly by spouses, other relatives and/or friends would be shifted to taxpayers.

Broad personal and family responsibility for long-term care should be encouraged through appropriate tax and savings incentives. Like Secretary Bowen, we believe that personal savings for long-term care should be encouraged by permitting tax deductible contributions to an Individual Medical Account and by allowing tax-free withdrawal of

Individual Retirement Account funds for any long-term care expense. We also support the principle of a refundable tax credit for long-term care insurance premiums in order to stimulate the private market for long-term care. Other tax incentives should be explored to encourage family responsibility for meeting long-term care needs. In addition, barriers to prefunding long-term care benefits provided by employers to retirees should be removed. Finally, we believe that the federal government and the private sector should work together to educate the public concerning the absence of coverage for long-term care under Medicare and Medigap policies.

Catastrophic Coverage for the Non-Elderly

While the focus of this hearing is on providing catastrophic coverage for the elderly, the needs of the non-elderly should not be overlooked.

The AMA believes that adequate health insurance, including catastrophic coverage, should be furnished in the employment setting. Such coverage can and should be encouraged by limiting the deductibility of employer health insurance premiums only to employers who furnish health plans that provide such coverage and who participate in a statewide risk pooling program. Risk pools can make basic health insurance (including catastrophic coverage) available, at reasonable cost, for persons who are uninsured, underinsured or uninsurable. Risk pools have been enacted in twelve states.

The current exclusion under the Employee Retirement Income Security Act (ERISA) of self-insured companies from state regulation has created an insurmountable impediment to the establishment of effective state risk

pools. We strongly urge appropriate amendments to ERISA that would allow states to regulate self-insured health plans for the purpose of requiring them to comply with state laws, including those requiring risk pools.

Workers who are laid off should have the opportunity to maintain employment-based health insurance for at least several months after their termination if they continue to pay the same portion of the insurance premium they paid while employed. In addition, we support the recently enacted legislation that requires employers to make group rate coverage available for terminated workers at the worker's sole expense for an additional 18 months.

Conclusion

The AMA believes that providing coverage for catastrophic acute care costs can be achieved at small additional cost and should be aggressively pursued. We believe that such coverage can be provided more comprehensively by the private sector than under the expanded Medicare proposals. If Congress decides, however, to provide catastrophic coverage through Medicare, such a program should be limited to acute health care costs and should provide some form of means-testing. We believe that broad personal and family responsibility for long-term care should be encouraged through appropriate tax and savings incentives.

Mr. Chairman, I will be happy to answer any questions Members of the Committee may have.

Statement

of

Blue Cross and Blue Shield of Michigan

on

CATASTROPHIC HEALTH CARE FOR SENIORS

Congressional Public Hearing
Monday, June 1, 1987

Blue Cross and Blue Shield of Michigan appreciates this opportunity to submit its comments on the issue of expanding Medicare to include catastrophic coverage and long term care. Blue Cross and Blue Shield of Michigan (BCBSM), other Blue Cross and Blue Shield Plans and the Blue Cross and Blue Shield Association, have been involved in the administration of the Medicare program since its inception in 1966.

In Michigan alone, BCBSM services about 1,100,000 beneficiaries under the Medicare program. In addition, it provides benefits to supplement Medicare coverage for about 660,000 beneficiaries.

It should clearly be acknowledged that the Medicare program does provide a necessary level of coverage to the elderly and infirm of this country. Without it, much of the population most in need of health care coverage for medical expenses would be left without protection.

Even so, for chronic or long term care, the Medicare program essentially provides no coverage. While this gap in coverage always has created the risk of hardship for Medicare beneficiaries, its adverse effects have been magnified as the incentives of the hospital prospective payment system have resulted in more frequent and earlier transfers of patients to nursing home and home care settings.

These benefit limitations do place beneficiaries at risk for financially catastrophic expenses. The need of the elderly for more comprehensive protection is clear.

The Private Medigap Market

The private sector has taken steps to fill many of these needs. Most Medicare beneficiaries are protected against excessive out-of-pocket costs for acute hospital and physician care by private coverage which supplements Medicare benefits -- Medigap. Nationally, 72 percent of the elderly supplement Medicare with private coverage, according to the Congressional Budget Office. In Michigan, about 2/3 of BCBSM's supplemental coverage is provided on a group basis - mainly through retirees' former employers - and about 1/3 is purchased individually.

The Issues

In testimony given by the Blue Cross and Blue Shield Association before the Congressional Committee on Finance on March 26, 1987, the Vice President of Government Relations, Mary Nell Lehnhard, offered comments on expanding Medicare to include catastrophic coverage. She defined the problem of inadequate coverage for the elderly as twofold:

1) For acute care catastrophic expenses, the most significant problem is affordability not the availability of adequate private health insurance, and,
2) For long term care, the problem is both one of affordability and availability. Medicaid requires individuals to become impoverished before they become eligible for long term care coverage. Also, for a number of reasons, the private insurance market has moved cautiously in this area, representing only two percent of all spending for long term care.

Proposed Solution

Since we understand that no new federal dollars will be available for an acute care catastrophic insurance program, we support an approach which incorporates this catastrophic protection within the Medicare program. We urge that consideration be given to providing appropriate financing for the low income elderly and that adequate beneficiary education occur at the outset to avoid the potential misperception that the restructured program will eliminate the need for supplemental coverage.

Certainly within this context, other factors must be considered. The most crucial involve correctly projecting future costs of a catastrophic program and eventually improving public and private financing mechanisms for long term care. On estimating future costs, two issues may surface. First, it is extremely difficult to reliably forecast the cost of new benefits and, secondly, it is even more complex to judge the behavioral response to changes. Both of these elements deserve consideration.

As far as long term care is concerned, we regard this as the largest coverage deficiency in the existing Medicare program. We recognize that due to its complexity, there exists no easy solution to the problem. It is clear that a mutual response on the part of both the public and private sector is imperative.

Other factors to consider include the likely draw away from Medicare Health Maintenance Organization (HMO) or Comprehensive Medical Plan (CMP) delivery systems, since the belief may exist among the elderly that a Medicare catastrophic program is more generous than an HMO or CMP plan.

Conclusion

In summary, Blue Cross and Blue Shield of Michigan is in support of Congressional efforts to restructure the Medicare program. We look forward to working with Congress in developing solutions to the problem of providing sufficient coverage for catastrophic illnesses while preserving the dignity of our nation's elderly.

STATEMENT OF JEAN CRAWFORD, FARMINGTON HILLS, MI

My aunt, Ola Chamberlain, died March 7, 1987. Nothing I do or say will change that, but I'm upset about what happened to her and I'd like to do what I can to keep it from happening to others. My aunt was 88, independent and well until she fell Feb. 17 and broke her hip. She lived in Ohio. I live in Michigan and was her family. I went to Ohio as soon as it happened and planned on going back for her move to a skilled care nursing home. One day, Mar. 5, before I was to go to Ohio, Southern Lorain County Hospital, Wellington, Ohio, moved her to a nursing home.

Her neighbor was with her and she tells me my aunt gave the appearance of being comatose. Regardless of her condition, they moved her. The nursing home took one look at her, found she had a temperature and she was immediately moved to the ICU at Allen Memorial Hospital, Oberlin, Ohio, where she died two days later.

I went to Southern Lorain County Hospital in Wellington asking WHY they had moved her when something was obviously wrong. They blamed Medicare which will pay for two weeks' hospital care for a broken hip.

What is wrong with us and our system when such a thing can happen! The hip was NOT the only problem. We are doing everything we can to have people live longer and then such a thing can happen.

We can send billions over the world for all sorts of reasons, but we push our elderly out of hospitals when they need tender loving care. This country's care of its elderly is a horror story.

STATEMENT OF JOHN M. ELGIN, ROYAL OAK, MI

If the Federal government is responsible for catastrophic health care, then a luxury sales tax and an unlimited Social Security tax on wages and bonuses should be enacted, and the $43,800 taxable limit should be scrapped.

The proposal by Congressman Stark is fatally flawed because 50 percent of persons over 65 will pay a progressive tax to provide care for 100 percent of those over 65. As the Michigan income tax is a flat rate, so should any tax, or premium, for catastrophic care be a flat rate.

The tax on Social Security benefits should be amended to eliminate inclusion of tax exempt bonds, and to raise the threshhold to $50,000 for married persons filing jointly.

I bitterly resent the idea that those who have more should pay more. I saved and sacrificed for my retirement income. Much of my retirement income has been eroded by the government's failure to maintain the constant purchasing power of the dollar.

STATEMENT OF JACK GOLD, FARMINGTON HILLS, MI

As the spouse and primary caretaker of my wife, who is an Alzheimer patient, I am worried about her care as this catastrophic illness progresses.

My wife, age 61, was diagnosed after almost a year of expensive and exhaustive testing and has had the problem for approximately 4 or 5 years.

Each year, her care has become more and more expensive. We have progressed from part time care to a combination of part time and day care facilities. At the present time, existing day care facilities won't keep her because she requires too much care. She now has a full time person with her during the day while I am at work.

Last year our care costs (including doctor bills, care and medication) were over $11,000. This amount was over and above our health care insurance costs.

This year, our estimated cost of caring will be well over $15,000 excluding our insurance costs.

The outlook for her care looks even more and more worrisome.

Even with home care, as the disease progresses, we could be looking at expenses that could exceed $30,000 per year.

The stress and the strain of being a caretaker is one thing, but the financial burden of this care can wipe out the savings of nearly 40 years of work.

We have tried to buy adequate insurance, but have been turned down.

We have been told that medicaid is not available to us.

We have been told that we could be facing many many years of financial disaster.

Both my wife and I had looked forward to these supposedly "Golden Years". I hope they don't turn out to be years of "Living Death".

From what I have read about the proposed Catastrophic Health Care for Seniors, A problem such as ours is completely overlooked. There seems to be absolutely no help for us. Do we deserve this fate?

Hospice of Southeastern Michigan

22401 Foster Winter Drive
Southfield, Michigan 48075
313/559-9209

May 27, 1987

Senator Donald W. Riegle, Jr.
c/o Ms. Pat Griebe
30800 Van Dyke Road, Suite 307
Warren, Michigan 48093

Dear Senator Riegle:

Thank you for your letter of May 13th, inviting the Hospice of Southeastern Michigan to testify at your hearing on catastrophic and long-term illnesses. I would like to provide testimony in the form of this letter.

In hospice care we have the privilege and honor to serve the terminally ill during the last six months of their life, if they choose to use our services. The hospice movement in this country is currently being challenged by three separate but overlapping problems. I would like to briefly discuss each.

Problem #1. Terminally ill patients without families.

Hospice often receives referrals from terminally ill patients who have no families. Since terminal illness results in the ultimate diminution in physical capacity such that ultimately nearly every patient becomes bedfast, being without a primary caregiver or a family support makes it impossible for the patient to stay home. While the Medicare regulations allow for hospice services to be provided in a nursing home context, it is either at the sole cost of the patient or, after he uses all of his available resources, he may appeal to the State Medicaid program for further assistance. However, the lifespan of the typical hospice patient in our program is 32 days. The waiting period for Medicaid support, provided adequate documentation of need is present, is approximately 90 days.

With the new Medicaid hospice benefit, the law allows for those patients who require extra support for room and board services in a nursing home facility. The hospice benefit under Medicare, however, does not have a similar benefit even though an equal number of these patients seem to require this same service. Under law hospice programs who receive Medicare benefits must treat all patients equally. Since we do not have the resources to pay for all patients who require extended care placement, we are unable to pay for any. I believe that a change in the Medicare hospice law would allow for support to those terminally ill patients most in need of support by adding a benefit for nursing home placement.

Problem #2. Alzheimer's Disease Patients.

Recently in the medical literature there have been articles detailing how a hospice approach to care for the severely demented Alzheimer's patient might in fact be a preferable method for treatment. The difficulty in accepting an Alzheimer's patient for hospice care is that the law restricts services to the last six months of life, and places an overall aggregrate cap of $6,850 on Medicare patients. Alzheimer's patients represent one of the real catastrophic illnesses that families face. Experience shows that the predictable life span of these individuals is not related to the degree of dementia nor is it related to any other identified signs or symptoms discovered to date.

I would recommend that serious consideration be given to a disease specific exemption from the six month/$6,850 caps that are placed on hospice care for patients with Alzheimer's Disease. I would further recommend that research be sponsored in the hospice movement to look at what appropriate care for terminally ill Alzheimer's Disease patients could consist of and to research what signs and/or symptoms point to a short life expectancy, around or less than six months in duration.

Problem #3. Acquired Immune Defficiency Syndrome (AIDS).

Like Alzheimer's Disease, AIDS is another dilemma for the hospice movement. It combines elements of both problem number one and problem number two above. First of all, AIDS patients frequently lose their entire support network when their disease becomes apparent. This is true because often the disease is the first indication that friends and family have that the individual may be a drug abuser or a homosexual. This often results in abandonment of the patient by his traditional social network. Again, this disease results in severe debilitation and the requirement for custodial/primary care from a 24-hour caregiver. Hospice does not have the resources to provide this level of care. All sorts of ad-hoc solutions are being sought, an example of which is the Wellness House in Detroit. Another problem with the AIDS patient is the unpredictability of the final phases of life. From the onset of full-blown AIDS life expectancy averages 1 1/2 years. The onset of full-blown AIDS signals terminal disease. That is to say, no one has ever recovered. Yet hospice services are restricted under virtually every benefit program to the last six months of the patient's life. Clearly in the disease AIDS, the onset of full-blown AIDS is a much better indication of the terminal phase of life than trying to predict the last six months. Another problem related to terminal treatment is that virtually all palliative care for AIDS patients consists of aggressive treatment of inter-current/acute infections of unusual organisms. These infections require intensive treatment often in a hospital intensive care or infectious disease unit, using extremely expensive intervenous and/or

oral antibotic treatment. When the hospice legislation was written, it was clearly written with the cancer patient in mind, where antibotics and intensive care are rarely required for the management of symptoms. Yet in the AIDS patient, the principle symptoms that require inpatient services almost always require hospital placement and extreme expenditures. I would like to recommend that considerations be given again to a disease specific alteration in the hospice legislation that would allow terminality to be defined as the onset of full-blown AIDS. This would make the term of care for hospice AIDS patients variable in nature. Secondly, it would be good to have additional resources available to assist the individual to acquire either live-in assistance in his or her home, or access to a nursing care facility. Finally, it may be necessary to re-phrase the law to allow the individual to move in and out of the hospice beneift as required to return to the inpatient setting for acute infectious disease control as palliative care for symptoms. Since the care of these acute infections requires the skills and services of infectious disease specialists, hospice would be unlikely to provide this level of service. Yet once the patient has elected hospice services, the hospice is expected to cover his symptomatic care. This simply creates a conflict beyond the skill levels and resources available to the hospice movement.

My staff and I would be available to you and your staff as needed to further explicate the above points. We believe that both Alzheimer's Disease and AIDS are issues and conditions that were not considered in the development of the origial hospice legislation. Both represent catastrophic and long-term illnesses which hospice has means to address, but is currently prevented from doing so by the way in which the various hospice benefit programs are restricted due to the law and the regulations attending it. Your leadership in trying to revise these regulations to address these two key challenges to our society and our health care system would be greatly appreciated by all in the hospice movement.

Sincerely,

Paul T. Werner, M.D.
Executive Director

cc: Michigan Hospice Organization
Wellness House

STATEMENT OF RICHARD W. AND LOUISE L. JAEHNS, TROY, MI

Many people in the 'mature' segment of our country are facing total financial devastation. Apparently reliance on our legislators has not been well-placed.

IMMEDIATE ATTENTION IS REQUIRED; DISCUSSION TIME HAS RUN OUT FOR ALL OF US. Catastrophic illness cannot be postponed until legislation is enacted, while taxes, medical and general household expenses continue.

We realize the costs will be ours, whether as taxpayers or caregivers. Our question to you is which will it be?

Your decision is essential in making the plans for our financial future.

TO: Senator Donald Riegle

FROM: Michigan Association of Retired School Personnel-
Western Wayne County Chapter;
Dick Gornick, Spokesperson

SUBJECT: Catastrophic Health Care Contingencies

PREFACING STATEMENT:

The ongoing evolution of societal needs often dictates the propitious moment for certain legislative action to take place. Such a situation now exists relative to the area of catastrophic health care for the following reasons.

I. The population of America is aging in a disproportionate manner. It has been referred to as the "graying of America", and statistics abound as to this being the faster growing sub-group in our population.

II. Major medical advances and improved technology are continuing to prolong life well into the seventy and eighty year old category.

III. Our major media sources have created an increasing awareness of the plight of many of our societal sub-groups such as the economically underprivileged, aged, etc.,etc. A high degree of populist support exists for legislation designed to mitigate the problems of such groups.

IV. A new emerging social consciousness exists relative to our less than exemplary handling of the problems of our elderly in the past.

SPECIFIC LEGISLATIVE NEEDS:

I. Medicare benefits expanded and improved to cover long term catastrophic illnesses including the cost of transplants and other prohibitively high priced procedures. The benefits of modern medical technology should be available to all.

II. Long term nursing home care provisions need to be included. The present costs of such care are decimating the meager life savings of our elderly. These costs regularly approach 2,000 dollars a month quickly creating a poverty level situation.

III. Quality control standards, along with a regulatory mechanism, are vital concomitants of such legisla-

tion. The Federal Government is in the best position to assist in this process.

CLOSING STATEMENT:

This organization is thoroughly cognizant of the intricacies surrounding the legislation process. It may not be possible to enact all such provisions in the initial legislation, but a real beginning needs to be made. Subsequent revisions and improvements can be made as our experience uncovers the need. Such an ongoing fluidity is a basic component of much of our social welfare legislation.

Michigan County Social Services Association

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June 1, 1987

Honorable Donald W. Riegle, Jr.
United State Senate
Attention: Ms. Pat Griebe
30800 Van Dyke, Suite #307
Warren, MI 48093

Dear Senator Riegle:

First of all we apologize for not personally attending your hearing, but we received your letter of May 13 on May 28th, and in talking with your Lansing staff, we were advised to provide written testimony in compliance with your invitation, to your Warren office.

The Michigan County Social Services Association promotes programs and policies designed to prevent medical indigence. We believe that adequate medical care helps to prevent social disabilities, to restore individuals to independence, and to prevent more serious problems for individuals and families.

Increased numbers of Michigan citizens are not covered by medical or hospitalizat6ion insurance. More than 900,000 people in Michigan lack public or private health care insurance. More than three-fourths of these people are "working poor" or their dependents. They could be forced into the welfare system due to the lack of proper medical insurance.

Many other Michigan citizens have insufficient coverage for catastrophic conditions or for long term care. In these instances, savings and resources are quickly exhausted. Once people become medically indigent, government programs may pay the bills, but the likelihood of returning to self-sufficiency is drastically reduced.

Other people may have sufficient insurance for catastrophic care, but lack coverage for preventive services or for early detection and treatment. Third party reimbursement often covers acute care after a condition deteriorates to a catastrophic level. In these instances, an individual or family may never fully recover.

Despite these problems, the federal response to health care needs continues to decline. More than $30 billion has been cut from Medicare and Medicaid budgets over the last five years. The presi- dent's February budget proposal calls for an additional $6 billion in cuts in Medicare and Medicaid in fiscal year 1988 and $22 billion over the next three years.

The Michigan County Social Services Association supports cost effective approaches to health care. Over the years, we have supported the expansion of health maintenance organizations (HMO's) and other case managed approaches to health care. We support increased emphasis to curb provider fraud and support innovative, efficient, and cost-effective systems for delivering health care. We encourage increased attention to wellness and to prevention of health problems and encourage the development of lower cost alternatives to chronic and acute care.

On a state level, the Michigan County Social Services Association identified improved access to health care as one of our highest legislative priorities for 1987-88. We recommended expanded services through Medicaid, a fair level of payments to providers, and increased monitoring of providers to prevent fraud. We also supported the development of a health care access project to extend coverage to the working poor and to general assistance recipients.

Although we continue to seek improved local and state support for health care, we know that the problems cannot be solved without increased support and direction on the federal level. New health care initiatives are needed. Comprehensive programs focusing on prevention and early treatment must be integrated with programs for long-term care and catastrophic coverage.

We are apprehensive about the development of new initiatives for catastrophic coverage or for long- term care while at the same time reducing funding for Medicaid and Medicare. We support the new intiatives if current services are maintained and if proper emphasis is given to prevention and to early diaognosis and treatment options. We also feel that efforts should continue to improve the efficiency of health care delivery and to reduce over-usage and provider fraud.

Thank you for your consideration of our concerns. The Michigan County Social Services Association appreciates your commitment to improvement in health care and stands ready to assist you with this goal in any way possible.

Respectfully,

Howard Dell

Howard Dell,
President

cc: Ralph Carnegie
MCSSA Board of Directors
C. Patrick Babcock
Kevin Seitz

Michigan Physical Therapy Association, Inc.
P.O. Box 21236 • Lansing, Michigan 48909 • Tel. (517) 694-8131

STATEMENT OF

MICHIGAN PHYSICAL THERAPY ASSOCIATION

ON

CATASTROPHIC AND LONG-TERM ILLNESS

This statement is written in conjunction with today's public hearing held by U.S. Senator Donald W. Riegle, on "Catastrophic Health Care for Seniors". It represents the position of the Michigan Physical Therapy Association in regards to pressing current health care issues, particularly as they relate to catastrophic and long-term illnesses.

The term "catastrophic" refers both to the debilitating condition and the expenses that result, and simply stated, the issue is how the nation's elderly are to cope with the devastating costs of major illness or disability. It is our perception that the greatest need to be addressed is the catastrophic cost of health care in situations after patients have been discharged from acute inpatient hospital care.

The Michigan Physical Therapy Association, through this statement, expresses its support for expansion of Medicare to provide catastrophic protection to Medicare beneficiaries for services presently covered by Medicare, and under certain conditions, to extend those services beyond the area of acute inpatient hospital care.

Since the implementation of the D.R.G.s and prospective payment system, patients have been discharged from acute care hospitals faster and sicker. As a result, more treatments, including rehabilitative treatments, have to be rendered outside the hospitals, creating opportunities for an expansion of alternative delivery, particularly in the areas of skilled nursing facilities and home health agencies. Beneficiaries who have been discharged and find little care available through the skilled nursing facility benefit, are equally hardpressed to find adequate care in their homes. Expanded coverage under Medicare for "homebound" treatments, including self-help and safety equipment, may provide opportunities for the beneficiaries to return to their homes.

Our position recognizes the growing elderly population demanding increased resources, the rapidly rising health care inflation, the large federal budget deficits, and the need for the program to adhere to strict cost containment principles. We are concerned with the assurance of the delivery of quality services, and the program must insure itself that the services are rendered by appropriately qualified professionals. We also imply that the program financing must be adequate to insure that fiscal responsibilities are appropriately shared between government and recipients, with no reason for any elderly citizen to be forced into impoverishment when stricken with serious or chronic health problems.

We express our appreciation to Senator Riegle who sparked the debate on this topic and thank him for the opportunity to present the position of the Michigan Physical Therapy Association on such crucial issues.

Detroit, June 1, 1987

Ratinaud

Jean-Pierre Ratinaud, PT,
President, MPTA

STATEMENT OF ROSE MONCHAK, ROCHESTER HILLS, MI

As I am not able to attend the meeting, I wish to express my thoughts here to you. Yes, me, here, had a "long term catastrophic" sickness experience. We just buried my husband five weeks ago who at age 74 (3 yrs ago) fell off a ladder He was very badly hurt, fell into stones and ended up with both arms broken, one rib broken & cracked pelvic bone — worst of all he injured his head which left him with brain damage which we were told by doctors was to be permanent & inoperable. After 3 months of hospitalization I had to take him home and care for him 24 hrs around the clock. Why? Because I could not afford the exorbitant amounts of money to pay at nursing homes. He was taken care of by myself & what help I could get from my 2 sons, who have families & homes of their own to care for. — This went on for 2 years & 8 months till the day he died.

2

Let me tell you, I am in my 70's and it was the most difficult chore to do. No matter, what day or time I had to many times force myself to take care of him, if I felt like it or not.

He was bed-ridden, wearing diapers and also a catheter, He had to be fed, as he couldn't function on his own at all. He had to be shaved and bathed and etc.

I understand our neighboring country (Canada) have nothing of the sort as we have here — no help — no care. Canadian people are shocked when I told them of our situation here. We, in the U.S. are not any poorer, than Canadians. Why can't we take care of the sick, aged and people in need.

P.S. — Had I placed my husband in a nursing home, by this time I would have "lost" my home (which I still have, thank God). Then myself, old age is upon me what would I do?

Thank you Mr. Rieck Jr.
Please do all you can to help people in situations such as I write about here. Rose Mrs. Mendel

STATEMENT OF THE MICHIGAN CHAPTER OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS, INC.

My name is Margaret Palmiter and I represent the 5800 members of the Michigan Chapter of the National Association of Social Workers. I am pleased to be able to address you this morning.

It is fitting that we should be represented here. Aside from patients themselves, no other group is as acutely aware of the gaps in our health care system as are social workers. It is the medical social worker who locates resources for the clinic patient who has managed to pay exorbitant prescription costs--but now has no money left for groceries. It is the hospital social worker who explains in detail the confusing and inadequate financing of nursing home placements to a family agonizing over the decision on how best to care for an ailing loved one. And it is the nursing home social worker who acts as an advocate for residents when our quality of care mechanisms break down.

Under our present system of federally-funded health care programs, only Medicare is available to the general population of elderly and disabled for coverage of catastrophic illness and long term care. The program as it is presently funded and administered does not provide adequate coverage.

As you will hear repeatedly today, the problems with Medicare are many. For example:

*Deductibles on hospital and physician care are inordinately high for many persons on limited incomes. To make it worse, the hospital deductible must be paid again in the same calendar year if the patient has been out of a facility for 60 days.

*Many of the benefits have inadequate lifetime limits, significant co-pays, or leave the patient paying costs over the maximum allowable charge. In general, the program seems to have more exclusions than coverage.

*Nursing home care is not covered at all at the basic level of care. Skilled care is covered in full for only 20 days following a hospitalization. A significant co-pay accompanies days 20 through 100. There is no coverage for extended care.

*Coverage of psychiatric care includes lifetime limits on hospitalization and annual limits on outpatient care that are woefully inadequate given the scope of mental and addictive disorders in our society.

*Medicare has no provisions for prescriptions, preventive services, and vision or dental care.

The end result of these restrictions is a system that punishes patients with long term, acute illness. It provides a disincentive for patients to receive preventive, less costly care. And it guarantees that most patients who require long-term care will be shifted to the Medicaid system, still funded in part by the federal government, although with some of the burden falling on the states.

The Medicaid system has its own share of problems:

*Low reimbursement levels for providers create a reluctance to serve Medicaid patients. Medicaid recipients therefore face reduced access to care, or may have to accept a lower quality of care. Nursing homes are especially affected by low reimbursement, with the present rate at less than $50 per day.

*The complexity of administration of the Medicaid program results in confusion, frustration, and needless delay for providers and patients alike.

The deficiencies in our federal "insurance" systems have brought about a related problem for seniors. Recent news reports indicate that many seniors purchasing so-called "Medigap" insurance policies, intended to supplement Medicare, have been taken advantage of due to confusing or misleading policies that actually provide them with little extra coverage.

Cutting across the entire helath care system are problems of staffing and personnel. A sufficient number of Registered Nurses are lacking at every stage, whether due to lack of availability or cost-cutting measures. Nursing homes suffer from inadequately-trained basic care personnel, accounted for by the absence of standards for training and low wages. And finally, recent federal cost-cutting measures have resulted in hospitals discharging patients requiring a higher level of care at home. While home health care personnel are available, reimbursement is often inadequate to provide these patients and families with the medical support they need.

We emphasize the following as priorities in improving our health care system:

*Coverage for long-term care in nursing homes, reimbursed at a reasonable level

*Adequate coverage for acute care hospitalization

*Expanded coverage for mental and addictive disorders

*Adequate coverage for home health care services

*Coverage for prescription drugs

*Coverage for preventive services

*Effective monitoring of quality of care

*Enforced standards for staffing of facilities and personnel training.

It is an unfortunate fact of life that the scope of coverage of any health care program will be determined by the financing that is available. There is no doubt that a health care program that adequately serves the elderly or disabled populations will be a costly one. As social workers, we understand that what is needed is a reordering of our national priorities to a system in which people matter more than military hardware. While we appreciate your efforts to this end, we realize that this is a very long-term goal.

Nevertheless, we have learned the hard way that cost containment in health care can be achieved through a system which emphasizes prevention and early treatment. Adequate coverage for necessary treatment can hold down costs by avoiding exacerbated medical conditions. Reasonable reimbursement levels can improve quality of care, and therefore cut down on related, costly errors. While extended acute care and long-term care will continue to be costly, we must realize that we are already subsidizing such care through the Medicaid program, as inadequate as it may be.

We thank you for seeking our input on this important issue and trust that you will work toward a comprehensive system of health care for our country.

STATEMENT OF KATHLEEN A. NEEDHAM, MADONNA COLLEGE, LIVONIA, MI

Good Morning! I am Kathleen Needham, Chairperson of the Gerontology Department at Madonna College, and a Commissioner on the Michigan Commission on Services to the Aging. In speaking to the issue on "Catastrophic Health Care for Older Persons", I would note that care of the chronically ill older adult is a very important and significant legislative issue for the Federal government to consider. I appreciate the opportunity Senator Riegel has given me to comment on catastrophic health care. The Federal government is losing ground in its capacity to preserve the quality of life for its aging population, particularly, related to health care. In the past, we have been an international leader in health services delivery to our aging population; but, today, we must play catch up just to provide the minimal catastrophic and long-term health care services that older people need.

The problem is how to get ourselves the best care possible at the least cost. Universal, catatrosphic coverage through Medicare appears to be the most efficient means. However, the current Medicare coverage and acute catastrophic illness coverage do not go far enough. There are many older persons in this country whose needs are not being addressed due to the lack of a commitment of resources to handle chronic illnesses.

The United States has a population that is rapidly aging and approximately 30 million Americans are 65 or older. The numbers of aged will continue to increase and create an old age crisis in American society if we do not develop appropriate public policies to meet the potential health care problems. Today, the fastest growing group of our population are those over age 75 who often develop chronic illnesses. The current coverage does not handle catastrophic complications leading to possible debilitation arising from chronic illnesses, i.e., Alzheimer's disease, arthritis, diabetes, emphysema, cancer, atherosclerosis, stroke, or heart disease. For example, a diagnosis of Alzheimer's disease can spell the probability of improverishing the well partner within four plus months as the couple are forced to sprend down to meet Medicare guidelines.

With older people, illnesses strike more frequently, last longer, and interact with other prevailing conditions. For example, recovery from a fracture or surgery may be a long involved process that could possibly be complicated by other conditions, such as, impaired circulation, diabetes, pneumonia. It is imperative that we protect people not only against acute illnesses but against the chronic illnesses as well. If we fail to respond to chronic illnesses, we may well spend many more health dollars by prompting more acute illnesses; and a person may end up in the hospital, as older people tend to experience more than one condition at a time.

If we fail to respond to the need of chronic catastrophic health care, we can expect to see an increase in acute care and institutional dependency. We will see persons who have to live in institutional settings and economic deprivation, shattering the American dream of independence. The grim reality of poverty in one's final days is a contributing factor to a general deterioration in the physical and mental health status of older adults who often could continue to thrive if their conditions were addressed by a health care system that responded to their needs.

Realistically, the goal for care of the elderly is often to simply manage the illness and to provide the optimum level of support for the individual to function at their level of capacity. We need a system that addresses the limitations of long-term care coverage for services under Medicare and Medigap supplemental insurance. It is imperative that America go beyond the acute catastrophic illness insurance for Medicare age group and include a comprehensive benefit program. We are the only industrial society that does not provide the appropriate health care our citizens need. Currently, United States health care costs consume 11% of our gross national product, the highest proportion of any nation. Specifically, we need to: 1) provide adequate home health care for those that have chronic conditions; 2) provide financial help for the 1.4 million older persons living in nursing homes; and 3) provide financial assistance to

the network of private care givers who provide nearly 80% of long-term care to the frail elderly.

The real challenge is to provide a "Catastrophic Health Care Program for Older Adults" that has comprehensive benefits and that will not escalate costs to the government and the consumer. An expansion of Medicare seems the realistic avenue to pursue.

It is essential that a solution to the problem of catastrophic illness be resolved soon. We are faced with an aging population that is growing at an alarming rate. It is only just and proper that we, as a nation, find a means to help older persons to live out their lives in dignity and peace.

Additional Issues = examine the following:
(1) Coverage for respite care, day care, home care and additional long-term care services.
(2) Support for family caregivers.
(3) Consideration of skilled and basic nursing home care.
(4) Consideration of out-of-pocket cap for health care.

Look at long-term care from a Continuum of Care perspective.

K Hall Adam

STATEMENT OF RANDY BLOCK, OAKLAND LIVINGSTON HUMAN SERVICE AGENCY

INTRODUCTION

Oakland Livingston Human Service Agency (OLHSA) is a community action agency which has responded to the needs of low income, handicapped and elderly persons in Oakland and Livingston Counties since 1965. Health is one of the agency's priority concerns. OLHSA welcomes the opportunity to provide comments upon the problems of catastrophic and long term illness before this hearing sponsored by Senator Donald Riegle.

PROBLEM STATEMENT

As an agency which serves persons of all ages, OLHSA has advocated for greater protection for the 37 million Americans under age 65 who have no health insurance protection at all. For many low and moderate income persons without health insurance, getting the medical care they need creates a financial crisis which can assume catastrophic dimensions. Faced with large medical bills, will the individual be able to afford food to eat, to pay their rent or to pay their fuel or utility bills? Savings may be depleted and property sold to pay for medical expenses.

In 1979, OLHSA sponsored a National Health Insurance Symposium to educate the public about problems in the U.S. medical system and to provide information on five major plans for changing/reforming this system, including a catastrophic health insurance proposal. Over 385 persons who attended this forum were surveyed as to which alternative they would prefer. Among the 174 persons who completed the questionnaire, a clear concensus was reached that 67 percent wanted a U.S. health system which provided compehensive benefits for all its citizens. (Thirty-six percent of those responding favored Senator Edward Kennedy's "Health Care for All Americans" and 31 percent favored Rep. Ronald Dellem's "Health Service Act" as their first choice for a national health plan.)

Based on these and other research findings, OLHSA determined that the following elements would be essential in a national health program: comprehensive coverage; same class service for all; freedom of choice for providers and consumers; a minimum of "red tape"; quality services; reasonable costs; and equitable financing.

Since the focus of this hearing is upon the health care needs of the elderly, a brief analysis will be provided regarding catastrophic health problems faced by the elderly.

Medicare was enacted in 1965 essentially to cover only a portion of the costs on an older person experiencing acute illness. Catastrophes which older persons now face in regard to medical expenses result from the lack of protection provided by our current medical system. A whole range of health services needed by older people are not covered by Medicare: prescription drugs; basic nursing home services; basic home health and homemaker services; hearing aids; eyeglasses; and health promotion/disease prevention services, such as a routine physical examination. Only about 44 percent of older persons' medical expenses are covered by Medicare.

The Bowen Commission's 1987 report on catastrophic illness includes data regarding the $30.2 billion out-of-pocket health care expenditures for the elderly during 1984 by type of service: nursing home - 41.6 percent; physician - 21.4 percent; hospital - 5.6 percent; and "other care - 31.3 percent. This includes expenses such as prescription drugs, eyeglasses and homemaker services.

Nursing home care costs can be truly catastrophic. A daily charge of $60 per day for a basic nursing home bed (which would be modest by current market standards) could add up to an expense of $21,900 per year. At this rate, life savings and resources of low to moderate income elderly and their families could be rapidly depleted. Catastrophic physician bills result from Medicare's design. After paying the Medicare Part B premium ($17.90 a month) and deductible ($75), the Medicare beneficiary gets coverage for 80 percent of the doctor's charge - up to the limit set by Medicare. However, seven out of ten doctors charge some of their patients more than Medicare is willing to pay. The patient must pick up these extra charges. The effect is that the real copayment, in many instances, is not 20 percent of the doctor's bill but 30 percent, 40 percent and even 50 percent.

Catastrophic health insurance proposals, such as the Bowen proposal, which provides extended hospitalization coverage would protect less than three percent of the Medicare population.

Catastrophic insurance protection against hospital and physician expenses does not address the whole range of health services (mentioned earlier) which older people need but which are not covered by Medicare, such as prescription drugs. Over 70 percent of the elderly's out of pocket costs come from expenses other than hospital or doctor services.

THE BOWEN CATASTROPHIC PLAN

On February 12, 1987, President Reagan formally transmitted to Congress his proposal for catastrophic health insurance protection for the elderly under Medicare. It was developed by Dr. Otis Bowen, Secretary of Health and Human Services. Major components of the plan are: Medicare beneficiaries would pay $4.92 a month in addition to their regular Part B premium. This premium charge has been projected to be actually between $6 and $7 per month. In return, seniors would be guaranteed that their out-of-pocket expenses related to services covered under Parts A and B would be no greater than $2,000 per year. This would include an unlimited number of hospital days. People would be encouraged to put money aside to pay for their own long term care through tax deductible Individual Medical Accounts like IRA's. States should take responsibility for providing catastrophic protection for persons under 65.

RECOMMENDATIONS BEYOND THE BOWEN PLAN

The National Council of Senior Citizens (NCSC), while commenting upon the Bowen Plan for catastrophic health insurance, has proposed that, at a minimum, this plan must include the following: full protection for low-income older people against excessive copayment deductibles and premiums under Medicare; coverage of additional benefits, specifically prescription drugs and lowering the $2,000 cap so more people will receive some expansion in long-term care.

OLHSA's Senior Citizen's Advisory Council has supported the "long term care" budget amendments of Rep. Charles Schumer which call for: protection against spousal impoverishment under the Medicaid nursing home benefit; raising the personal need allowance for Medicaid nursing home residents; and making Medicare home health care benefit more available to Medicare beneficiaries.

CONCLUDING REMARKS

Until a comprehensive national health plan is instituted to protect all U.S. citizens, OLHSA will continue to advocate for reforms which will make health care more affordable and accessible to the low income, handicapped and elderly. Appreciation is expressed to Senator Riegle for sponsoring this forum to address catastrophic and long term care health needs of the elderly.

Pontiac Area Urban League, Inc.

50 WAYNE STREET
PONTIAC, MICHIGAN 48058
Telephone
335-8730 338-4581

June 1, 1987

Senator Donald W. Riegle, Jr.
30800 VanDyke, Suite 307
Warren, MI 48093

Dear Senator Riegle:

Pontiac Area Urban League is very pleased to submit this testimony regarding catastrophic and long-term illnesses. Our experience is rooted in the needs of blacks and other minorities of Pontiac area who for the most part have never had equal access to health services nor adequate income to afford appropriate health insurance.

Thirty-seven million Americans face a financial catastrophe from any serious illness because they lack any form of insurance. Blacks, other minorities and the poor in general are disproportionately represented among these.

It is estimated that twelve million children under the age of eighteen are uninsured. Again, blacks, other minorities and the poor in general are in double jeopordy.

Therefore, we urge that you continue your efforts to address the bulk of the need for catastrophic coverage protection...the 37 million uninsured and 20 million underinsured Americans, most of whome are poor or near poor, and the growing number of elderly, disabled, blacks and other Americans, who are being crushed by uncovered long-term care costs for chronic illnesses and disabilities.

Sincerely,

Hugh Jackson

Hugh Jackson
President

/vh

STATEMENT OF AVARD B. READ, ROYAL OAK, MI

I am taking this opportunity to let you know how unhappy I am about the way the Bureaucracy treats those in need of Health Care and Social Security.

Briefly I am 62 and had a heart attack July 30, 1986. I have no health insurance. I told the Doctor I could not afford to go to Hospital. He said I must go and must get the Hospital Social Service to apply for Medicare. Hospital Bill 7/30/86 to 8/3/86 $2801.55. I am self employed in a one man Automobile Brokerage business and I have used up the little money I had saved to run out five months ago.

My Contact with Oakland County Dept of Social Services, 3111 W John R Madison Heights, Mich 48071. Phone 583-8774.

My Case Worker were D. W. Orrell seemed like a nice person. Mrs J Williams seemed like a nice person. Mrs J Clark a dishonest woman (who signs her name heartlessly), and John A Lewis - a Secret "Jack Ass" who likes to impress you with his importance.

My Contact with Dept of Health and Human Services PO Box 715 150 Main St Royal Oak 48068 Phone 546-0653. Through the efforts of Congressman Levins Office, Miss Mc Lee and Herbert Schneider

~~Page 2. (cont'd)~~

5/1/87 I got my first check of $534.00 for Social Security & Mr Middleton and Mr Russell seem determined to put stumbling blocks in my way for SSI, Medicaid and Medicare.

I have been sending in reports on everything and it always seems each department already have some way of finding another loop hole to open up.

Instead of helping they seem determined to destroy me and my business.

STATEMENT OF JOHN E. LATTILA, VICE PRESIDENT, RETIREES ASSOCIATION OF WAYNE STATE

The Retirees Association of Wayne State, representing almost 1,000 retires, hereby joins the American Association of Retired Persons (23 million members) and James Roosevelt's National Committee to Preserve Social Security (4.5 million members), two other powerful organizations representing senior citizens, in endorsing Representative Claude Pepper's comprehensive H.R. 65, the Catastrophic Health Insurance Act of 1987 (companion Senate billS. 545 has been introduced by Senator Sasser D-TENN).

Medicare, Medicaid and private medigap policies simply do not provide any coverage for long-term catastrophic illness which can impoverish most senior citizens. The Administration backed Bowen plan provides only minimal catastrophic illness coverage. Representative Pepper's H.R. 65 would cover short and long stays in hospitals, skilled and custodial nursing home and home health services. His plan would introduce a Medicare Part C which would be financed by a supplementary premium and a Medicare payroll tax for upper-income workers.

Representative Pepper, in a letter published in the AARP News Bulletin of May 1987, states that under his plan "no senior would spend more than $800 a year or 10 percent of his income (whichever is less) for all his needed health care". This is much less than the $2,000 ceiling proposed in the Bowen Plan and much less than the current cost of private long-term illness insurance and none of these provide comprehensive catastrophic illness coverage.

Quoting Representative Pepper again - "It would be a tragedy to accept less, at a time when the nation is ready to do so much more." The members of the Wayne State University Retirees Association urge you to support Senator Sasser's Senate bill 545 which is the companion to Pepper's H.R. 65.

Thank you for this opportunity to express our concerns regarding this important matter.

STATEMENT OF GEORGE A. RISKO, WARREN, MI

WHY SHOULD I FEEL SORRY FOR THE TWO NEXTDOOR NEIGHBORS WHO WOULD FIND LIFE DIFFICULT IF NOT IMPOSSIBLE TO COPE WITH WITHOUT BEING SUPPLIED BOTTLED OXYGEN TO ASSIST THEM TO STAY ALIVE AND OTHERWISE TO PROLONG THEIR LIVES. BOTH SITUATIONS RESULTED FROM THESE INDIVIDUALS SMOKING EXCESSIVELY THROUGHOUT THEIR ADULT LIVES. YET IF YOU SUGGEST TO ANYONE THAT PERHAPS WHATS WRONG WITH THEM — COUGHING FEELING BAD, STOMACH TROUBLE, ETC — WELL IS NOT THAT THE DOCTOR IS NOT A MAGICIAN BUT THEIR SMOKING, DRINKING AND THE LIKE. MAY CONTRIBUTE TO THEIR MALCONTENTS

I HAD THE UNFORTUNATE EXPERIENCE TO HAVE HAD A HEART ATTACK IN 1967. NOTWITHSTANDING ALL OF THE MEDICATION THAT I HAVE TAKEN I DO HONESTLY BELIEVE THAT GIVING UP SMOKING BENEFITTED ME THE MOST. WELL IT WAS A TOUGH UP HILL BATTLE — FOR 10 YEARS OR MORE THE ONE THING THAT I DESIRED MOST WAS A COUPLE OF DRAGS ON A 50 CENT CIGAR. MOST OF THE SMOKING I DID WAS SECOND HANDED AND YOU KNOW TODAY I DETEST MORE THAN ANYTHING TO BE PLACED

(2) (2)

IN A ROOM WHERE ONE OR MORE PEOPLE SMOKE — CAR, WORK, RESTAURANT — ANYWHERE. MY WIFE DOESN'T SMOKE / AND I BELIEVE THAT HELPS BOTH OF US A WHOLE LOT

NOT TOO LONG AGO OUR PARENTS HAD TO PUT UP WITH CATOSTROPHIC ILLNESSES. IT WASN'T EASY BUT WE MANAGED WE BOTH CAME FROM LARGE FAMILIES AND THE HARDEST PART WAS THE LACK OF CONCERN ON THE PART OF THE MAJORITY OF THE FAMILY MEMBERS. IN MY CASE THE FAMILY IS SCATTERED THROUGHOUT THE COUNTRY HOWEVER THE OTHER SIDE OF THE FAMILY WERE ALL WITHIN AN HOUR OR SO / FROM WHERE HER MOTHER LIVED WHATS THE POINT OF THIS - WELL BOTH HAD INSURANCE BUT YOU KNOW THERE COMES THE DAY WHEN NORMAL TREATMENT CEASES TO BE A PRACTICAL SOLUTION AND THE AILING PARENT MUST GET OUTSIDE HELP. NEIGHBORS, CHURCHES AND OTHER CIVIC GROUPS WONT RESPOND. ALL OF US HAVE TO DO WHATEVER WE CAN TO MAINTAIN SOME SEMBLANCE OF DIGNITY IN THE CLOSING DAYS IN THE LIVES OF OUR DEAR ONES. MY [illegible] WAS [illegible] TIL SHE PASSED

(3)

(3)

WITH REGARDS AS TO WHO BEARS THE COSTS I (WE) BELIEVE IT SHOULD BE THE INDIVIDUALS RESPONSIBILITY YOU BUY A CAR OR A HOUSE AND ITS UP TO YOU TO MINIMIZE THE RISK OF LOSING THE PROPERTY AND ALSO TO REDUCE ANY LIABILITY THAT COULD OCCUR FROM UNFORESEEN ACCIDENTS AND MISUSE. YET THERE ARE TIMES WHEN EVEN PRUDENT JUDGMENT MUST ABORT.

* UNTIL I WAS 21 I HAD NO INSURANCE. MY WAR INJURIES WERE TAKEN CARE OF SUCH AS IT WAS. YOU LEARNED TO TAKE CARE OF YOURSELF AND WERE TAUGHT THAT DOCTORS WEREN'T THAT DEPENDABLE IF ESSENTIAL FOR THAT MATTER. WELL DURING THE 50'S THE UNIONS STARTED FLEXING THEIR MUSCLES AND DEMANDED MEDICAL BENEFITS. SLOWLY THE MEDICAL INSURANCE BENEFITS EXPANDED UNTIL ABOUT 1975 WHEN THE WORKERS WERE COMPLETELY COVERED. NOW THE EMPLOYERS ARE ATTEMPTING TO REDUCE THE COSTS OF MEDICAL INSURANCE COVERAGE BY INTRODUCTION OF ALTERNATE PLANS, PARTIAL PREMIUMS IMPOSED ON THE WORKER OR RETIREE, REDUCTION OF PRESCRIPTION COVERAGE ETC.

(4) 5)

As a retiree of Chrysler I can see an end to the unlimited coverage.

4) What do I think of the Government getting in the insurance business. Well the Tax Reform Act of 86 is still fresh in my mind. Also I strongly suscribe the the fact that even though there's a doctor for every 500 or so of us, anytime you may want one of them to be in your service, the doctor will either be on vacation or can't be reached. Believe me it's already happened to me more than a couple of times.

Rochester Kidney and Hypertension Center
Internal Medicine • Kidney Disease • Hypertension

May 30, 1987

Senator Donald Riegle
30800 Van Dyke
Warren, Mi. 48093

Dear Senator Riegle:

I appreciate the opportunity to present written testimony to you through your Health Care Hearing.

My concern is with the End Stage Renal Disease program which provides life saving services to patients whose kidneys no longer work and must be dialyzed with the artificial kidney machine two to three times a week to live. Omission of one dialysis can put the patient's life in jeopardy.

The dialysis itself is a specialized procedure with many variables that have to be changed according to the individual needs of each patient based on their physical condition and laboratory tests. Some of the services provided during dialysis include establishing the length of the dialysis, changing the formula of the dialyzing fluid, the amount of water to be removed from the patient's body during each dialysis, monitoring of vital life signs, review of symptoms, maintaining proper diet control,etc.

To pay the physician for his renal related services, Medicare instituted a fixed monthly payment per patient. This is called the Monthly Capitation Payment (MCP). Historically, the interpretation of this MCP was to cover services provided during dialysis. It has been interpreted as such by Medicare since the initiation of the ESRD program 14 years ago.

At the present time the definition of what is covered by capitation is being changed by the Medicare carrier in Michigan following directives from HCFA Regional Office in Chicago. The concept of "renal related" is being expanded to include all medical care for all medical conditions except the following:

Neoplasms
Thyroid/Pituitary
Hypothalmus/Thalmus gland
Mental retardation, psychosis, schizoprenia
Multiple Sclerosis
Myathenis Gravis
Huntington's Disease
Degenerative Disease of the Central Nervous System
Cataracts/Glacoma
Trauma, sprains, broken bones, accidents.

Please see Attachment 1 prepared by Blue Cross Blue Shield of MIchigan and distributed

Carlos Marchena, MD
121 Hampton Circle • Rochester, MI 48063 • 853-5155

to representatives of the Renal Physicians Association of Michigan at their meeting on May 6, 1987. The list of exclusions was also provided at that meeting.

What do these developments mean for the patient? It means that the nephrologist will have the responsibility to provide services to the ESRD patient which may be out of the scope of his practice, which he may not have performed for many years, for which he will not be paid and for which the patient cannot go to another physician. This will have a negative effect on the quality of patient care and severely limit the patient's access to care. When a patient is being evaulated for a kidney transplant, physician specialists from different fields contribute to this evaluation process. Yet, according to the new guidelines, this will no longer be covered by Medicare.

Every Medicare patient, who is not enrolled in a Medicare HMO, has free choice of physicians and specialists based on the patient's needs. The patient can go to a lung specialist or to a heart specialist if he needs one. Medicare will pay 80% of what it considers reasonable customary charges if a medical need is demonstrated. According to this new proposal, an ESRD patient cannot do this. HMO Medicare patients have the choice of enrolling in an HMO plan or maintain their free choice status. According to this proposal, ESRD patients will be treated as HMO patients without their knowledge or choice. Physicians will not be paid for the volume of services they provide nor for the level of responsibility and risk they assume when treating ESRD patients.

Limiting the access of one group of Medicare patients to physician services because of their disease is discrimination. Institutionalizing discrimination in a federal program is reprehensible. Yet this is what Medicare is proposing in the State of Michigan.

I would appreciate your views on this situation and would be happy to work with you or your staff to resolve this problem.

Yours truly,

Alice K. Marchena

Alice K. Marchena
Manager

ATTACHMENT I
"DRAFT"

REVISED PROCESSING OF MONTHLY CAPITATION PAYMENT
AND RELATED SERVICES

Effective immediately, Medicare claims submitted for the Monthly Capitation Payment (MCP) and related services will be finalized on a quarterly basis. This means that initially, reimbursement will be made for both the MCP and any physician services (eg., office, inpatient visits, etc.) that are furnished to an End Stage Renal Disease (ESRD) patient by the patient's attending physician or by a different physician.

However, in all instances when reimbursement has been made to the same or different physician for related services that are covered under the MCP, an adjustment or recoupment is to be expected.

Please note that when a physician elects to receive a prorated MCP in proportion to the number of days a patient is hospitalized, the MCP will be reduced by 1/30th for each day of hospitalization.

When the MCP and medical visits other than inpatient are furnished but are subsequently determined to be related to the MCP, the reimbursement of the MCP will be adjusted based on the reasonable charge for the level of care furnished.

It should also be noted that recoupment action will be taken against a physician who furnishes medical care to a ESRD patient when the diagnosis is related to what Medicare is reimbursing the patient's attending physician under the MCP.

As a reminder, the MCP and medical care (ie., inpatient or office etc.) furnished by the same physician during a month must be submitted on the same claim. In addition, the date of service for the MCP must be the last day of the given month with the only exception being when the patient dies before the end of the month. In this instance, the date of service should be the last day of care furnished to the patient.

COLLEEN CAGNEY MSW, ACSW
CERTIFIED SOCIAL WORKER
SOCIAL WORK SERVICES FOR Y.OUNG &
O.LD
U.NITED

820 S. MITCHELL ST.
CADILLAC, MI 49601

PHONE
775-0828

The Honorable Donald W. Riegle, Jr.
The United States Senate
30800 Van Dyke
Suite 307
Warren, Michigan 48093

May 28, 1987

Dear Senator Riegle:

Thank you for inviting me to your senate hearing on catastrophic and long-term illnesses. I regret that I will be unable to attend, but would like to make the following comments.

Respite care for severely disabled people living at home is essential for providing family members with the relief and support they need to maintain an in-home placement. I think that people living at home should be eligible for the same insurance coverage as one would receive residing in a nursing home.

Insurance policies that do not exclude coverage for catastrophic illness is another area that needs attention and action.

Thank you for considering my opinion.

Sincerely,

Colleen Cagney ACSW

Colleen Cagney, A.C.S.W.

CC:pt

City of Southfield

26000 Evergreen Road
Southfield, Michigan 48076

May 26, 1987

Senator Donald W. Riegle
30800 Van Dyke
Warren, MI 48093

Dear Senator Riegle:

This is written as an answer to your request for responses related to the health care issue of catastrophic and long term illness about which you are holding a Senate hearing on Monday, June 1, 1987 in Warren.

We are all painfully aware of the need of a plan for assisting persons who go through such a catastrophic experience in their lives and are faced with the emotional, psychological and financial trauma that accompanies such illness.

I understand there are presently in Congress, nine (9) separate bills related to this particular concern which directly affects such a large portion of our population and which could very easily happen to any of us.

I want you to know, Senator Riegle, that I fully and whole-heartedly endorse and support your efforts to pass legislation which will address this problem especially because it will affect many of the city's workforce.

My concern is, as is the concern of everyone involved with the legislation, what will be the source of funds to support an adequate insurance program for addressing this problem.

My understanding is that the primary sources of funding being considered are:

1. The Federal Government's General Fund
2. Increased premiums paid by those who carry medicare insurance
3. A larger payroll deduction for the Social Security with a greater portion of the funds going to medicare

MAYOR DONALD F. FRACASSI | COUNCIL PRESIDENT PETER J. CRISTIANO | CITY CLERK PATRICK G. FLANNERY | CITY TREASURER ROMAN J. GRONKOWSKI | CITY ADMINISTRATOR ROBERT R. BLOCK

CITY COUNCIL

VICKI GOLDBAUM | SUZANNE GOLDSTEIN | STEVE S. HURITE | SIDNEY LANTZ | ELI E. ROBINSON | BARBARA TALLEY

From my view point, the last two of these three alternatives are quite undesirable; both add to the burden of the individual. Already so many individuals are weighed down with more taxes and demands than they can handle.

The third alternative leaves me with an even greater concern. If the Social Security Deductions are increased it means that not only will the individual portion, but also the City's portion of the payroll deduction will escalate. This increased cost will cause a real difficulty to the City.

As a City, we have experienced several financial problems in recent years. First, a few short years ago there was the recession. Then, insurance rates ballooned out of proportion along with many other costs. Now public safety and aging roads as well as demands for improved roads, are a drain to us. Legislation therefore, that would require more of our City's resources for increased insurance programs, would cause a very serious burden to the City. In fact it would probably cause us to lessen significantly the number of employees working in the City. Thus the solution to the problem would have consequences which are also catastrophic.

From my point of view, I recommend that as you proceed with promoting this legislation every effort be made to provide funding for the program from sources other than through personal or local funds. Perhaps now is the time and this is the occassion for us as a country to evaluate how we as a country use our General Fund money and set priorities. Does our spending substantially improve the quality of life of some of our most needy people from every class of people? This program could give that assistance to many.

We very much want such a bill, Senator Riegle. We support your efforts. We just ask that it be funded realistically, responsibly and with fairness to all.

Thank you, Senator Riegle, for your consideration.

Sincerely,

Vicki

Vicki Goldbaum
Councilwoman
City of Southfield

/dkd

STATEMENT OF ESTHER N. CALLAHAN, CO-ORDINATOR
WATERFORD SENIOR CITIZENS PROGRAM

Adult day care programs are a relatively new service that are being offered to frail, older adults. They enable many people to remain in their own home or in the home of a relative, as opposed to being placed in a nursing home.

Adult day care programs operate in the same way as children's day care centers. Participants are dropped off in the morning for a supervised day of activities and then returned to their homes. Because of the high cost of nursing home placement, the longer society can provide services that enable seniors to remain in their home, the more economical for everyone it will be. Legislation needs to be passed that will allow tax credits for adult day care costs.

The Federal government needs to differentiate between a medical model adult day care program and a social model adult day care program. Medical models are designed for therapeutic and rehabilitative purposes. Social models provide a caring and protective environment and help to motivate and to stimulate each individual's ability. Because of the amount of expertise and training required in caring for medical model participants, medical models should be licensed. The health insurance industry should recognize medical models and develop criteria for support.

Licensing is not necessary for a social model adult day care prgoram but these kinds of programs should be in conjunction with a senior center as part of their activities. A strong linkage with a senior program will prevent isolation as well as provide access to other supportive services in the community.

The Federal government needs to look at ways to ease the financial burden of an aging population. Adult day care programs are an economical and preferred alternative to nursing home placement.

STATEMENT OF NANCY J. VALUET, OUTREACH DIRECTOR,
WATERFORD SENIOR CITIZENS PROGRAM

Many aging people have no way to prevent a lengthy illness and resulting nursing home stay from wiping out a lifetime of savings. With nursing home costs averaging about $65.00 per day, or $23,725.00 per year, two-thirds of all nursing home patients who start out paying their own bills are impoverished within a year.

As a counselor for people over age 55 at the Waterford Senior Citizen Center, I am more aware than ever of the need for long-term insurance and long-term nursing home coverage. Many of the people with whom I deal, especially family members of Alzheimer patients, are primarily concerned that they will outlive their savings. These are people who thought they could retire with a comfortable life, and found that longevity and inflation wreaked havoc with their plans. I find that most people are willing to pay their fair share...but where does one draw the line when faced with ten or twenty years of nursing home expense? Many frail spouses are taking care of an infirmed loved one at the expense of their own health because they do not have the finances for long-term nursing care. Who pays when the caregiver wears out or dies?

Many people think it is a child's responsibility to take care of their parents in their old age. Today, people are living to age 90 and 100. That means their children are 60, 70, or 80. We are facing a situation of old people taking care of very old people, a new phenomenon in today's society. If these children spend their savings on care for their parents, who will pay when they need it?

Currently, Medicare and most insurance coverages do not cover the cost of non-skilled care in a nursing home. Most of the frail elderly are in nursing homes for custodial or non-skilled care. Must a spouse spend all of their life savings on nursing home costs and spend the rest of his/her life in poverty? It is time for the Federal government to recognize the change in today's population. More and more people are living longer and will be facing the possibility of long-term care. Some provisions must be made to insure quality care in later life at a cost that is affordable to all.

STATEMENT OF PEARL WHITT, NEW BALTIMORE, MI

In accordance with your letter May 1987 Re: Public Hearing on Health Care for Seniors, 7/8/87. Being concerned I contacted several senior citizens who are neighbors and friends with regards to the program. Rising medical care is everybodys problem. It consist of a few i.e: A. The seniors with whom I talked to have to have additional Medical Coverage w/ Blue Cross or other. Those that had this Coverage are happy with the Medical Care because they could not make it with out it. Quote "I would lose everything."

B. If they do not have separated insurance with prescription they must pay their own.

C. If they had only medical care would be in dear need of additional aid through

the medical program.
Increased medical Expenses
would defienatly be a
problem.

Thank you Lon Reiner Jr.
for your attention to this
matter in their behalf;
seniors are pleased that
you care and wish
the meeting a success.

I had to go to the
post office for a zip code
because the letter you
sent did not have one, so
unfortunally if they can not
attend the meeting will
probably not reply unless
they do it by writing to Washington.
I wanted to attract more
attention to the Warren meeting
so it can aid you for
direction in Washington.

CATASTROPHIC AND LONG-TERM HEALTH CARE

MONDAY, JUNE 22, 1987

U.S. SENATE,
COMMITTEE ON THE BUDGET,
Flint, MI.

The committee convened, pursuant to notice, at 10:07 a.m., at the Prahl Center, 1401 East Court Street, Flint, MI, Hon. Donald W. Riegle, Jr., presiding.

Present: Senator Donald W. Riegle, Jr.

Staff present: Joan M. Huffer, legislative assistant; David Krawitz, legislative director.

Senator RIEGLE. Let me try to get us started here this morning. I want to, first, inquire if anyone here, who has a hearing impairment or who is deaf because we have a signer here, as you can see, beside the table; and if there is anyone who needs the use of that help, we want them to know it, and, perhaps, even to come down closer to the front so they can see her.

If anyone can see the message from the signer, will raise their hand—we don't know that we have anyone. Well, we may not require your help. Maybe you could stay a little bit longer to see if anyone else comes. I very much appreciate your being here and your help.

Let me welcome all of you here this morning. I have a number of important points to make at the outset. I want to be sure that you have the basic information as background before we get into hearing the testimony from our witnesses.

OPENING STATEMENT OF SENATOR RIEGLE

Senator RIEGLE. First, I want to welcome all of you here this morning. I appreciate very much your attendance. I want to thank the Mott Community College for opening up this facility for us today.

This is an official hearing of the Senate Budget Committee on the subject of Catastrophic Health Care needs of our senior citizens and on the health needs of uninsured people of all ages.

So, we're going to focus on both of those issues today; catastrophic health care needs of senior citizens, and the health care needs of people of all ages who presently are uninsured, and in some cases, underinsured.

Now, we have some very important witnesses who have agreed to come today and give their testimony. After they have finished, we will, then, take statements from anybody in the audience who wishes to speak, and it's very important that if you have some observations to make on the health care problems that face us, you

use today's opportunitv to tell us what you know, or tell us what you're experiencing.

I don't think anybody needs to feel uneasy about it, and I'm willing to come and stand with anybody that wants to come up to the microphone and tell their story.

So, it's very important that we have a chance to get an actual complete record because this will become the basis for which we draft and attempt to pass legislation in Washington.

Now, if there are others here who have thoughts on the health care problem, and you don't want to speak, then, I'd like you to write those thoughts down, and we'll provide a paper and pencil for everybody that wants to do that, and we'll insert those comments in the record as well if you would rather not speak at the microphone.

Now, let me, first, talk about the problem of health care for senior citizens because the catastrophic health needs are enormous in the country today, as you will hear from some of our witnesses just a little bit later.

Our current Medicare program has many major gaps in it, despite spending, as a society, $74 billion last year on Medicare services. Hundreds of thousands of senior citizens were driven into poverty by huge medical bills, bills that were not covered and not paid by Medicare or any other coverage.

As we know from personal examples, and those that we learn about, a person's entire lifetime savings can often be wiped out by a single major illness, where the bills just overwhelm the financial circumstances of that person.

That problem has to be changed, and legislation has been proposed to make some important changes to our health care system.

Now, President Reagan has made an important proposal to improve catastrophic health coverage for senior citizens, and whether you agree with that particular proposal or not, I think, he deserves credit for raising that issue and bringing it forward at this time.

Secretary Bowen, who is the Secretary of Health and Human Services, has been actively involved in developing this proposal, and, to give us an opportunity in this session of Congress to actually enact some legislation that can help meet some of these extraordinary health care needs.

The President has laid down a requirement for this new legislation, however, that any changes or any added coverage under Medicare to provide for catastrophic health coverage must be paid for directly by the people involved; that there will be no additional government payment; that the people who are going to get the benefits are going to have to provide the costs for those benefits.

So, with that guideline having been laid down, it's important to understand that while we will have broader coverage and new protections under the Medicare law, if this legislation is passed, the basic approach is that Medicare beneficiaries will pay a higher monthly premium to pay for these new protections and benefits. The Congress has been working on legislation to improve on the administration's proposal. I would like to talk about the bill currently under consideration in the Senate.

Under the Senate proposal, out-of-out pocket expenses under Medicare would be limited to a maximum of $1,700 a year. That

would be the most that somebody would have to pay for a catastrophic illness, and in many instances, people would pay less than that.

So, no matter how long you needed to stay in the hospital, you would be fully protected under this new proposal. No matter how many times you needed to go to the doctor for medical treatment for illness, you would not pay more than the maximum of $1,700 a year out of your own pocket.

Now, obviously, this means going to doctors who accept Medicare payments. The Senate bill would also expand coverage for skilled nursing home care, for home health care, and for hospice care; and while the President's proposal did not provide coverage for drugs or medicines, we're trying to put that into the bill, as well, because that's a major problem, as we know.

I've already had one person today come up to me and talk about the cost of monthly prescription drug costs that are almost beyond her means. In fact, she's not even taking the amount of medicine that her doctor tells her she should take, simply because she doesn't feel she can afford to spend that much each month just on those medicines.

This is how the improvements would be paid for.

Presently, Medicare beneficiaries pay a premium of $17.90 a month. It comes right out of your Social Security payments if you're in that group. In order to get this new catastrophic health insurance coverage, the basic Medicare premium would go up $4 a month.

So, it would go up from $17.90 to $21.90. Everybody who is on Social Security and on Medicare would pay this premium.

There would be an additional supplemental premium that would be based on ability to pay. Persons with higher incomes would have an additional payment for this catastrophic health care coverage, but that premium would be far less than what most people now pay for Medigap policies.

As you know, many people—and I'll show you the stats on the chart in a minute—have medigap coverage, which they pay for privately to provide coverage that Medicare does not presently provide. If this new national policy is enacted, many of those Medigap policies would not be needed. Therefore, instead of paying the premium for these private policies, you would be paying a smaller premium for the new government coverage. The supplemental premium would range from as little as a dollar a year, up to a figure of $800 a year.

Only seniors with a very high income would pay the higher premium. Sixty percent of those that are on Medicare wouldn't pay any supplemental premium at all. It would only be the group of 40 percent with relatively high incomes that would pay the supplemental premiums; and, as I say, most of those folks are now paying for private Medigap policies. They would, in most instances, be able to stop doing that, so there would be a cost saving on that side.

We have some materials to explain this legislation in greater detail that we hoped to pass out today. We made the mistake of checking those materials with Northwest Airlines. We haven't the foggiest idea where those materials are right now. They may be in Alaska or Timbuktu, but they're not here in Flint.

We're hoping the box may arrive before the hearing is over; but if not, we want to send to you this material so that you can really take a look at these proposals and react to them.

Now, bear in mind, these catastrophic health care insurance proposals that are being considered in Washington now deal only with health care for acute illnesses, within the present scope of Medicare.

It does not cover routine medical exams, dental care, eyeglasses, or, unless we can beef it up, prescription drugs. There is another huge problem and a growing problem facing many of our seniors, and that is the need for long-term care.

Under Medicare today, long-term nursing home care is not provided unless you spend all of your money, and you finally qualify, under the welfare rules for Medicaid. Only then can you receive coverage for longterm nursing home care.

Medicare, itself, does not provide that kind of coverage. For many people, the most important catastrophic health problem that they face is the problem of long-term care. People in nursing homes last year spent on the average, $22,000 for nursing home care.

It doesn't take long at those levels of expense to wipe out a person's life time savings. So, it's very important that we try to find some answers, as well, to provide for long-term nursing home care and for home health care.

We have a lot of people who are quite elderly and who are being cared for in the homes of relatives. That's expensive, and it's a very difficult situation many times for the families involved. So, we need to consider, also, in the future how we deal with that problem.

Long-term nursing home care is now costing about $37 billion a year in this country, and, as I say, unless you're broke, and you are on Medicare, you're not eligible for coverage in that area.

So, this is a major problem for which new answers are needed. The proposed legislation requires that we undertake a study, a very careful study, to try to figure out how to deal with the cost of long-term nursing home care and home health care to try to come up with some answers in that area.

Now, I want to cover one other thing, and I'll quickly cover the charts, and we'll go to the first witnesses. This area of law is complicated enough that it's important that you have some of these basic facts to start out with.

We, also, have another major health care problem with people of all ages—those who just have no health insurance whatsoever. As you know, we're having some serious layoffs and plant closings in the Flint area. After people who have had health care coverage because they were employed exhaust that coverage, which will be extended for a period of time after their job is gone; unless they find another job, many of those people will be uninsured. There are many people today who are working who have no health coverage whatsoever, and I'll show you those statistics in just a minute.

Many of the people who are not uncovered by any health insurance at all today are children. I've heard about many cases where people have been reluctant to go to the doctor, or take their children to the doctor even when they need care because their finan-

cial situation is so tight. They just can't afford to do it or don't feel that they can and they don't have health insurance to provide some kind of financial help.

What often happens, then, is people delay going for medical attention until their problems often are far worse. When they finally do go, it's a far more desperate situation, and often times the problems are much harder to solve, and much more expensive.

Between 30 to 40 million Americans are completely uninsured today, which is about 15 percent of our population. In addition, there are about 75 million Americans that are under the age of 65—about 35 percent of our whole country—who are underinsured; they have some insurance, but it doesn't come close to being adequate. This problem of not having health insurance covers all age groups in all regions of the country.

The number of people without health insurance has increased forty percent since 1980. In fact, 5 million Americans now say that they do not seek health care because they're unable to pay for it; and that's just not right in the United States of America in 1987.

We're a rich enough and strong enough country that we have to find a way to put ourselves in a position where every citizen of this country, if they are ill and need medical attention, has the ability to get it whether it's a senior citizen or a child or somebody in the age in between.

This is a very serious National problem, and as I've said, we've seen in many instances where people who don't go for treatment when they need it, end up with far worse problems later on.

Now, there is legislation that has been developed to try to deal with this problem of people who are totally uninsured, and I have developed a proposal that I have been refining now over the last 4 years. In much the same vein, there is an alternative proposal that has been developed by Senator Kennedy.

Our financing mechanisms are different, and I'll touch on that in a second; but however we elect to do it, the important thing is we must try to find a way to structure a system where we can provide a health insurance plan for those that have no insurance at all, and to be able to, get it enacted, and then—pay for it. It doesn't mean anything if we can't get it enacted. If we can't pay for it, it's, obviously, not going to work.

The approach that I have developed is one that uses what's called a pooling mechanism, which would provide insurance for any uninsured person. When a person receives the insurance, they would be asked to make a payment, if they can, based on the ability to pay. The program would be financed by States through new and existing State, country, and local funding, through premiums that would be based on a person's ability to pay, and on a tax on the operating revenues of the hospitals in a State.

Now, the hospitals don't like that, and understandably so, and I don't particularly want to put an unfair burden on them, although today the hospitals are, in fact, bearing much of the cost of people who don't have health insurance who come to the hospitals desperately needing treatment. So, in a sense, we're trying to find a better situation than the one we have now.

Senator Kennedy's bill would provide similar benefits, but it's only aimed at those people today who are now working but lack

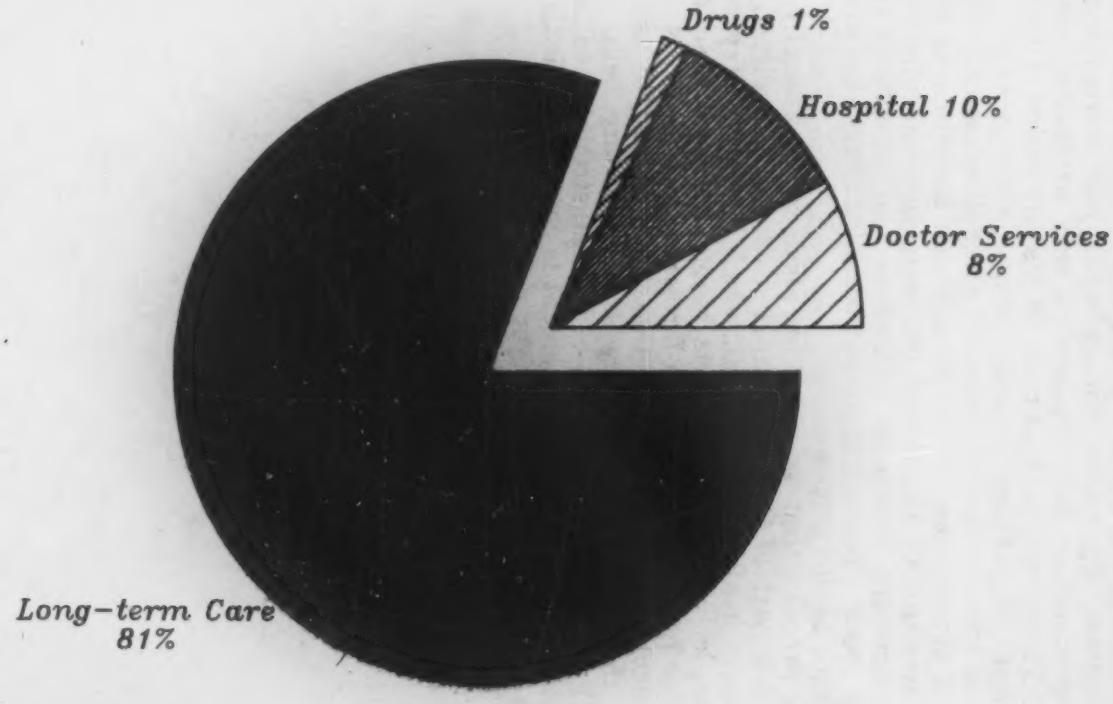
health insurance. My plan would deal with not just those who are working but the unemployed, as well, those who are unable to find work and have no health insurance. So, our bills are different in that respect.

Senator Kennedy's bill would require businesses to provide coverage, and that's an alternative approach in terms of paying the premiums with presumably some contribution by the workers, themselves. But I'm concerned about whether that approach can be enacted. I want to get something that we can put in place because we have a lot of sick people of all ages out there today that need help and attention, and they're not getting it, and especially children. I'm particularly concerned about that because they're unable to fend for themselves.

Now, if I may, I want to just show you a couple of charts here, and we'll go right to the witnesses. Let me give you an idea how dramatic this problem is.

What we have on this chart is an illustration of the catastrophic, out-of-pocket health care costs facing the elderly people today. This is what our senior population is experiencing; you'll notice that the overwhelming bulk of those costs fall under the category of Long-term Health Care; about 81 percent of all the expenses of a catastrophic sort for health needs for senior citizens are in the area of long-term care.

CATASTROPHIC OUT-OF-POCKET EXPENSES OF THE ELDERLY



Office of Senator Donald W. Riegle, Jr.

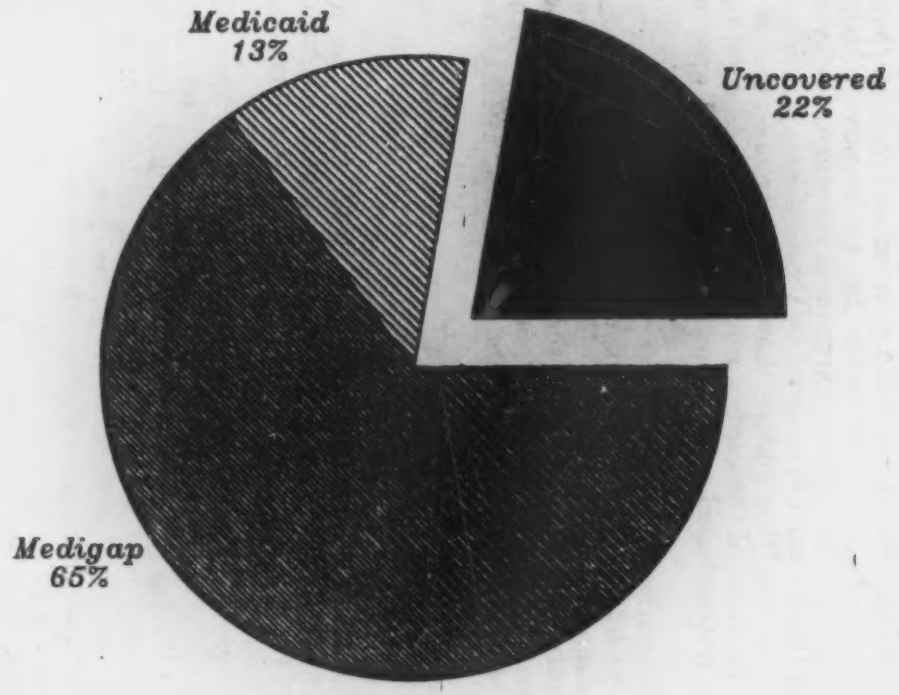
Now, the rest of the costs tend to be incurred when a serious illness occurs. My father, for example, had a very serious heart bypass operation; five bypasses; a very expensive, complex operation. There were a lot of costs in a short period of time. That's a very common problem for many people in our society.

Those kinds of costs for specific acute illnesses fall into this category of catastrophic health costs which insurance or Medicare do not cover. About 10 percent represent hospital bills; about 8 percent represent payments to doctors and physicians of different kinds; about 1 percent represent costs for drugs that are needed to deal with health problems.

The proposal that we're talking about today, basically, deals with just this part of the problem. It does not deal directly with the long-term health care problem, which is a very, very, serious one.

Now, let me exchange charts here. This chart, also, shows catastrophic health care coverage for senior citizens. This chart shows how acute health problems—those represented by the blue area from the previous chart—how those bills are being met today. You'll see here that in terms of the catastrophic health care costs for senior citizens, about 65 percent is covered by Medigap policies. Many of you would have Medigap policies.

CATASTROPHIC HEALTH CARE COVERAGE FOR SENIOR CITIZENS



Office of Senator Donald W. Riegle, Jr.

Let me just inquire with a show of hands of those of you that are now Medicare age, how many of you have Medigap policies of one kind or another? Would you raise your hands? [Audience complies.]

There are probably 25, 30 hands. So, you're paying today out of your own pocket for that supplemental coverage. Today about 65 percent of those costs are covered by those Medigap policies.

Now, if we pass this Federal Law, we'll replace most of that. In other words, most of these costs would then be paid right out of the Medicare system based on this new approach that I was describing earlier.

About 13 percent of these costs are paid by Medicaid. This means people who have exhausted all of their resources, obviously, can't afford Medigap coverage and, in effect, go onto the welfare system.

Then, there are 22 percent of these costs that aren't covered by Medicare, Medicaid or private insurance. This comes right out of people's resources. Sometimes debts that are accrued that can't be paid.

So, this part is not covered at all, and under the new system we would cover this, as well. So, we would be able to pick up that part of the chart.

Just a couple more here, and, then, we'll go to our next witnesses. I apologize for the fact that this initial presentation takes as long as it does, but if we don't set a frame of reference, a lot of this won't be clear.

We've been talking about seniors with respect to Medicare. Now, I want to come over to the other side of the problem, and that is people of all ages that lack health insurance, including, for example, our unemployed workers in this area who either get laid off and their coverage expires, or even workers who are presently working but just don't have any health insurance coverage.

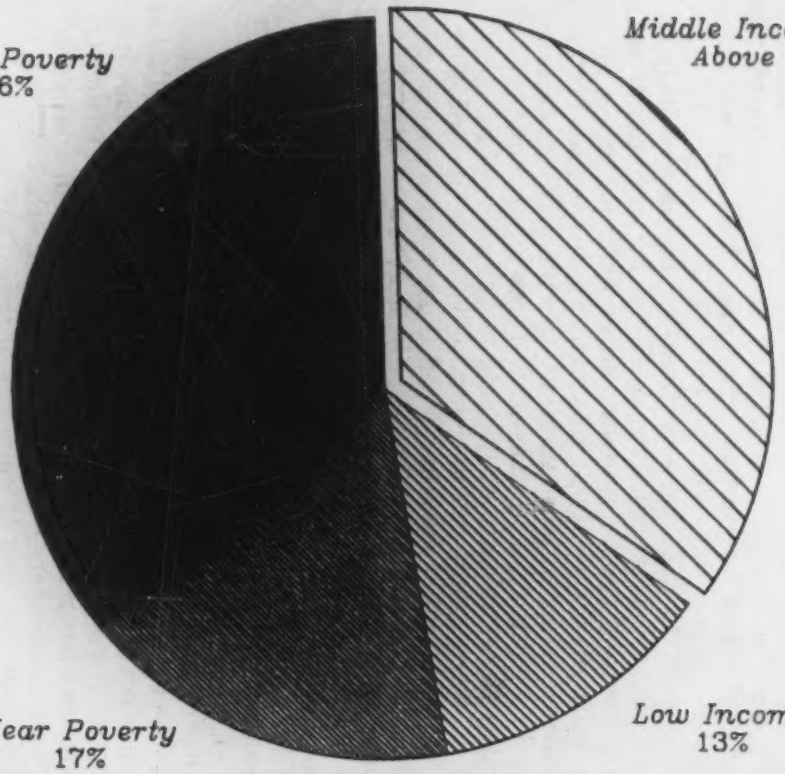
When you take a look at the non-elderly population who lack health insurance, we find that 35 percent of those people alone, thirteen million people are presently working. They may be working at a McDonald's or at Taco Bell, or whatever, but they just don't have any health insurance coverage at all as part of their job.

Then, you've got about almost an equal amount, 32 percent, about 12 million who have no health insurance who have no job at all. They may be laid off. They may not be able to work. They may be in an area where it's very difficult to find work. They may not have the skills to be able to work, but in any event, there's this group.

Then, also, about a third of the total, about twelve million are children who have no health protection whatsoever. Some of the children would be living with families that have no jobs. Some would be in families where somebody is working, but there's no health insurance. This gives you an idea as to where the uninsured are and the fact that, roughly, a third of the uninsured in our country are children at the present time.

Finally, this chart. If you look at the family income of the uninsured people in our country that are under the age of 65, you'll find that 36 percent are below the poverty line, and, obviously, are just having a very hard time holding body and soul together.

Family Income of the Uninsured
(Under 65 Years of Age)



Office of Senator Donald W. Riegle, Jr.

Seventeen percent in this orange area are near poverty; 13 percent are what we call low-income people. So, they're out of poverty, but just barely.

Notice this—a full 35 percent of the people who have no health insurance whatsoever are called middle-income. This shows you that even though we call it middle-income, the pressures, the financial pressures, are such that many of the people in that group are unable to afford health insurance, and, therefore, are not presently covered.

A system to take care of these problems obviously, has to be based on an insurance concept, where, for example, if we take this whole room of people, and structured an insurance plan that takes into account everybody in this room to provide for certain kinds of catastrophes or interruption of income-type protection, we can afford to do it for a lot less if everybody participates in the group because the problem is only going to get a few of us.

If it were going to hit everybody, then, it would be a much higher cost. But if we can spread those costs over the whole group and maybe only 5 or 10 in the whole group in the end have large expenditures, the premiums that are paid in will be affordable; we can afford the protection and hope that we're lucky enough not to be one of the 10 or 15 that really need to draw the big benefits.

If we are one of those people, we would have protection, but only because the premium is affordable with support from a large group.

That's the whole idea of insurance. It makes good sense. That's why if we can build an insurance pool at the Federal level that in a sense covers the whole national population, we can get the efficiencies to go with the broadest possible participation; try to hold those costs down as much as we can to see to it that people are not driven into absolutely impossible situations that destroy their lives, and destroy the lives of members of their families.

So, with that, I'll call on our first panel of witnesses, and you'll get an idea of some of the problems that people are facing, and why this is an urgent issue.

I'm going to start with Mrs. Susan Rasak, who is here with her father, Mr. Albert Brooks, who is right over there.

Susan, would you just stand so people can see you. We're going to have witnesses speak right from the table here because it's a little more convenient, but this is Susan Rasak, and your father is with you.

Mr. Brooks, do you want to, also—are you willing to just stand for a minute so people can see you. This is the gentleman she's going to speak about, and he's here with his wife, as well.

Now, Mr. Brooks suffers from chronic health problems that require him to pay large sums of money out of his own pocket. We're going to hear about this problem that they're facing trying to make ends meet. Mr. Brooks is 64. He receives Social Security Disability and Medicare. So, Sue, with that, we appreciate you being a witness, and we'd like to hear from you; talk right into that mic as strongly as you can.

STATEMENT OF SUSAN RASAK

Mrs. RASAK. As the Senator said, my name is Susan Rasak. I appreciate the opportunity to testify today on behalf of my father, Albert J. Brooks. I know that his story is just one of many that you will hear today, but I hope that it will give you an idea of what life is like for someone who cannot afford adequate health care.

My 64 year old father suffers from severe chronic physical problems. His main complaint is Addison's Disease, which affects the male hormones. His other ailments include liver disease, nephritis, kidney problems, anemia, blood in his urine and glandular problems. He has, also, suffered minor strokes, as well as undergoing open heart surgery.

He's in such poor health that he is totally unable to work. He is retired from Michigan Glass Company but receives no pension or health benefits from his former employer. He has been on Social Security Disability since 1977.

His monthly income from that is $686, on which my father and mother must live, as my mother is too young to qualify for any benefits of her own.

Their household bills add up to approximately $450 per month, not including the money they must set aside to pay their taxes each year. His small income is hardly enough to support one healthy person, let alone two people where one is chronically ill.

My father's medical bills leave him barely enough to afford food at the end of the month. His prescriptions alone in the past have totalled $143 just for one month. That amount includes $70 for Cortisone which he will have to take for the rest of his life in order to stay alive.

The doctor is trying some generic, synthetic brands to help them save money, but they don't work as well, but he's tried that because of the extreme cost.

Currently, he owes McClaren Hospital $1,100 and has in the past owed as much as $2,000. That's the co-pay amount that Medicare requires. He, also, has many outstanding doctor bills, and he's had to see a minimum of seven specialists since the first of the year.

We've been advised that he'll have to see more specialists. The specialists are only partially covered by Medicare. He is a proud man. He wants to pay his creditors, but he can only afford to pay each of them a few dollars a month. He has applied for Medicaid, but that hasn't worked out either.

I really feel that my father's low income and lack of adequate health care is jeopardizing his health even further. He is embarrassed to make appointments with a lot of the specialists that he sees because he knows he can't afford to pay them. As a result, his health deteriorates, and, then, he has to go to the hospital as an emergency case.

So, when he enters again, not only does he owe the money that I mentioned to you in the past, it increases by another $520. I would like to share with you an excerpt from an article about Addison's disease, and it states, quote, "The stress of infection, surgery, or injury will increase the need for extra hormone replacements. Patients with Addison's disease must be closely supervised, medically," unquote.

How can my father be closely supervised for this chronic disease if there isn't enough money available for the necessary care of a specialist? I'd, also, like to add that my mother has an extreme hearing loss, and she needs a very expensive, high-powered hearing aid.

Now, the Lion's Club did supply her with one, very generously. We appreciate that, but it isn't sufficient for the loss. The one that she needs runs about $750, and there's no way they can afford it. Both of them need eyeglasses. Dad hasn't had eyeglasses since 12 years, and in the past, short time ago, mom and dad wanted to borrow on their home to pay off the medical bills, and I begged them not to because I thought that was their only security, and they certainly couldn't afford another payment.

In conclusion, I'd like to say dad has worked hard all his life since he was 14 years old, and they don't ask for a lot, mom and dad. They just want to be comfortable and have the adequate health care needed to keep them that way for as long as possible.

With my father's health problems, the chronic ones, he'll need continuous monitoring and prescriptions. I would just like to make sure that he can have those, and that other people that need them can have them, also.

Thank you, again, Senator Riegle.

Senator RIEGLE. Sue, thank you, very much for coming, and I want to say to your father and to his wife that we're very grateful that you're here, and you perform a very important public service by coming.

I know it's not easy to do it. I know it's not easy to have these things talked about in a public way, but you do a great service to others and to the country to tell your story because it's the story of millions of people across the country.

The legislation that I've been describing here this morning would meet your problem almost perfectly. In other words, it's designed precisely to pick up people like yourselves who have these bills that go way over and beyond what the present coverage is, and that's one of the reasons why we think it's so important to get it enacted so it can be there to help people live their lives, as you say, in a reasonable fashion without worrying every last minute of the day how the next bill is going to be paid.

So, I'd like to inquire how long did you work for the glass company?

Mr. BROOKS. Well, I worked, between the two of them, for about 25 years.

Senator RIEGLE. So, you worked for 25 years, but, if I understand correctly, there is no——

Mrs. RASAK. Benefits.

Senator RIEGLE. Benefits of any kind.

Mrs. RASAK. No pension.

Senator RIEGLE. No pension, no health care; so, you gave all those years, but now when you're at a point when you need some protection that you might have gotten that way, unfortunately, it's not there, and I think, illustrates why we need a national approach to this problem that can meet the needs of people exactly like yourselves.

Well, I thank you, very much. Let us move now to our next witness, and that is Lisa Davidson, and Lisa is here with their 6 year old son who has undergone surgery twice since he was born.

Mrs. Davidson's husband is self-employed, but he can't afford to purchase health insurance for his family because of the financial pressures that they face, and she's going to describe the problems that this has caused for her family, and we're very pleased you're here and that you brought your son today.

STATEMENT OF LISA DAVIDSON, CLIO, MI

Mrs. DAVIDSON. Good morning. My name is Lisa Davidson, and I reside in Clio with my husband, Dan, and my two sons, Dan and Jay. Currently, we owe over $2,500 in medical bills for our son Jay's recent surgery.

Now, 6 years ago Jay was born, and I did have health coverage through my place of employment, but as I quit working when he was born, the coverage quit. Jay was born with a Dermoid cyst on his right eye that had to be removed by the time he was two.

We could not find any medical coverage, and we went to the Knight Templers who took care of all the bills. I did not see any bills. The only request they had was a picture of Jay before and after surgery, so, that they could let other people know what they did for people.

Now, Jay was, also, taken for a routine teeth cleaning at Mott Children's Center in March of this year, at which time they found a tumor in the top of his mouth.

They sent us directly to Ann Arbor, and within 14 days, he had surgery which removed the tumor and one tooth. Now, at that time they could not tell us whether it was benign or malignant then, and we found it's not malignant, but it does have a tendency to grow back, and in doing so it is very aggressive and rapid rolling.

So, we are not only looking at current bills that we owe, but maybe in the future more surgeries which we hope does not happen. We do not receive any Medicaid or public assistance in any way, since we're self-employed.

We are making our own bills, but we cannot afford health insurance. So, we kind of have to just go from one group to another. If we buy more equipment, we could end up just selling it again in order to get any Medicaid or coverage in that way.

So, it's kind of a Catch-22. We try as hard as we can to be self-employed and keep our own business going and raise our children, but it seems the more we do, the more we struggle. I'm, also, on a Health Policy Committee for the Hamilton Avenue Family Health Care Center, and this is a Federally funded organization that helps the indigent in the area.

I think, clinics of this kind are very important in our community, and they need to be more in the public eye. We go there for dental and medical care for the entire family, and I do hope that these concerns will be addressed quickly, and——

Senator RIEGLE. Lisa, thank you, for testifying. Let me ask you a couple of things.

When you were a young person growing up and before you were married but, presumably, hoping some day to be married and have

a family, did you ever imagine that when you got to that point and had children, that you were going to find that these medical bills were going to be almost a constant preoccupation for you?

Did you ever imagine that that might happen?

Mrs. DAVIDSON. I did to the point that my father was self-employed, and he had his own self-insurance. He did afford Blue Cross, which was a blessing because he has now had open-heart surgery, also, and I know he takes 15 kinds of medicine a day, and the bills are outrageous.

Senator RIEGLE. How much stress does this cause on your family with you and your husband to try to make ends meet; keep your head above water; you're working. You say, you're trying to be self-employed.

How do these financial pressures affect, do you think, and do they affect your family?

Mrs. DAVIDSON. Tremendously. It comes down to paying a doctor $5 a month, or putting a muffler on the truck so that you can go meet the next job the next day. It's no priorities. Everything is priority.

Senator RIEGLE. Can you tell us about what it would cost if you were to have private health insurance that would cover your family? Do you know off-hand what that cost would be per month?

Mrs. DAVIDSON. Six years ago, I paid Blue Cross when Jay was born, and it was almost $400 a month.

Senator RIEGLE. Right.

Mrs. DAVIDSON. I don't know what it would be today.

Senator RIEGLE. Well, it would be substantially higher. She's saying, I don't know if her voice is carrying to the back of the room, but 6 years ago, it cost $400 a month for that kind of family policy, and, of course, it would be, I think, substantially higher than that today; but under the current situation, you just don't have the money to provide that coverage.

There, again, in this situation, if we can get a National program established that will provide an insurance coverage system for people who are now uninsured, whether they're working or not working, this was the second thing that I was describing up here.

That would reach the problem that you're facing, and, we, obviously, would have to devise the right kind of financing mechanism, and there might be a sliding scale.

You might be expected to pay something, but it would be within reach in terms of what you would actually afford, and we would find a way to spread those costs in such a way that you would have the coverage and still be in a position where, if you find another problem arising in the family, you would feel that you could have it treated properly and people get the care that they need.

I thank you for coming to testify today. I know it's not easy to talk about these things, but I'm very proud of you.

Mrs. DAVIDSON. Thank you.

[The prepared statement of Mrs. Davidson follows:]

PREPARED STATEMENT OF LISA DAVIDSON

My name is Lisa Davidson. I reside in Clio with my husband Dan and our 2 children Danny 15 and Jay 6. Currently we owe over $2,500.00 in medical bills for our son Jay's recent surgery.

My husband Dan is a self-employed sign maker and I work part-time at H&R Block.

Six years ago when Jay was born, I had health coverage through my place of employment. Jay was born with a Dermoid Cyst on his right eye causing a loss of sight. By age 2, the cyst had grown and needed to be removed from the surface of his eye. At that time we were denied medicaid due to excess income and did not qualify for assistance from Crippled Childrens. The Knight Templers, which are a part of the Masons, paid for his surgery. I did not receive copies of the medical bills, however, I believe they were approximately $1,200.00.

The only stipulation for assistance from the Knights was a request to provide them with a before and after surgery picture of Jay.

In March of 87 Jay was taken to Mott Childrens Clinic for a routine dental exam. A growth was discovered on the right side of the roof of his mouth. A referral was made to a local oral surgeon who immediately made a referral to U of M's Dental School. At the time of Jay's initial exam at U of M, I explained to the doctor that I did not have medical coverage. He kept reassuring us that Jay would be treated regardless of our lack of insurance and not to worry about the bills.

During the initial exam, the Dentist's were unable to determine the extent of the tumor or if it was related to the cyst that had been removed from the surface of Jay's eye.

In March, Jay had a giant cellular granuloma tumor removed. U of M's Dentists stated that Jay had a very rare tumor that may at any time begin to grow. Should this occur, the growth is generally very rapid and aggressive. We pray daily that this tumor does not reappear as next time it will likely result in the loss of teeth and removal of part of the bone in Jay's face.

We are very thankful that there is no relationship between the cyst on Jay's eye and the tumor in his mouth.

Due to my husband's seasonal and fluxuating business we may apply for Food Stamps during the months when Dan's gross income is less than $1,018. Usually once a year we apply for medicaid, however we have never received it. In January when we applied for medicaid, our spenddown was $6,012.00. This means that from January to June of 87 we had to incur and are responsible for the first $6,012 in medical bills.

We have also applied to Crippled Children's for assistance with Jay's surgery. At this time we have not received a decision that his medical diagnosis is one that is covered by Crippled Children's. They did assist with the cost of a CAT scan used to determine the extent of the tumor.

Jay is struggling to stay self-employed and since he works from our home, I function as his office manager; answering the phones, keeping the books and assisting customers when they pick up their signs.

We can not afford health insurance as Dan's income is seasonal and dependent upon his customers for payment. We are also in a Catch 22, if Dan should purchase any major equipment to increase his business, all equipment and supplies are considered assets by DSS and this would insure that we would never be eligible for medicaid never mind the spenddown that we have not been able to meet.

Both boys receive physicals and dental care at Mott Childrens Clinic. They were referred there after the need for Jay's eye surgery was discovered.

Since we do not have medical insurance, I am very concerned with providing my family with quality, affordable medical care. Three years ago I was in need of dental work and was referred to Hamilton Ave. Family Health Center, a community based health clinic with sliding fee scale. I have served on their Board of Directors for the past 2 years. Currently, I serve as the Chairperson of the Health policy planning committee. Through my volunteer work on this Board, I am becoming increasingly aware of the rising costs of insurance for the Clinic and for doctors. These costs are reflected in the increase in medical charges and copayment that clients receive.

I do hope that your committee will address all health concerns, medicaid rules and regulations, insurance fees and increased funding for health clinics to serve medically indigent clients.

Senator RIEGLE. Mrs. Gilliam, we're very pleased to have you with us today. Now, you have a serious health condition, and you recently had major dental work done. Your husband was laid off for an extended period of time, and I gather could be laid off again.

You're going to talk to us today about the strain it's caused when health insurance coverage is maybe there 1 day and, then, not the next and what that has meant as you have seen it.

As Joan gets the—I want to just introduce—I'll do that a little bit later, but I'm going to ask you to lean into the microphone so that everybody can hear you in the back of the room, and we'll have you go ahead at this time.

STATEMENT OF SUSAN GILLIAM, FLINT, MI

Mrs. GILLIAM. I hope you can understand me because without my teeth, I don't talk plain.

Senator RIEGLE. OK. Well, I'm sure we'll understand you.

Mrs. GILLIAM. Hello, my name is Susan Gilliam, and I am 35 years old. I reside in Flint with my husband and three sons, 17, 14, and 13.

George went back to work in June after having been laid off for 7 months from Shamrock Manufacturing. At his plant, they make bins and racks used by GM and other manufacturers. From October 1986 until June 1987, George was unemployed due to his plant experiencing a slump in the auto industry and internal management, a partnership was being dissolved.

My husband has Blue Cross/Blue Shield, also, Master/Major Medical which pays 80 percent of the prescription and office calls after a deductible of $100 per person of $200 per family is met.

Shamrock generally pays health benefits for the first 3 months an employee is laid off. However, due to my extensive and serious medical problems, Shamrock periodically continued to employ George on a part-time basis so that we would continue receiving health coverage.

All income that George received was deducted from his unemployment check, so, in reality, George did not receive an increase in his income by working part-time.

In 1985 after extensive, expensive medical tests, it was determined that I have a weakness in my heart muscle, and I am not pumping enough oxygen and blood throughout my system. My doctor has stated that due to my heart condition, I must avoid stress of any kind.

For the past 1½ years, I have had dental problems, my teeth were beginning to loosen due to gum disease. The first dental estimate was for $1,200 for extractions and partials. The second estimate was for approximately $1,000 to have all of my teeth removed as the dentist did not believe they could be saved due to the gum disease, and he wanted to put me in the hospital immediately to remove them.

Because of my heart condition, it could not be done in a dental office, and his estimate for false teeth would be $800. My husband's company does not provide dental coverage.

Since we are still paying on a 1985 hospital bill for an accident my 15 year old son had, I did not consider my teeth to be a major health risk until October 1986. Although, at times I was in considerable pain due to the loose teeth and sensitivity to hot and cold foods or cold air.

In October, I began having several infections that would reoccur. My medical doctor finally traced the infection to my teeth, and by this time, extensive gum disease.

I was placed on an antibiotic to clear up the infection and sent to an oral surgeon, who wished to immediately place me in the hospital to remove all of my teeth, as the infection was placing great stress on my heart.

In October, we had applied for food stamps and Medicaid. We began receiving $115 in food stamps; however, our Medicaid spendown was $1,236 from October 1986 to March 1987.

In November, my husband phoned Blue Cross to determine if they would cover the extractions. He was informed that they did not cover extractions. Meanwhile, I went to Hurley Hospital who stated that I may be eligible for Hill Burton Funds, however, they did not cover the dentist's bill, anesthesiologist's fees, et cetera.

I was attempting to meet my Medicaid spendown as I was getting more and more prescriptions and having to visit my doctor more frequently, as the infection would not go away.

By chance in February, I was discussing my deteriorating health talking to my mother about my health, and she asked if I had called Blue Cross and told them how severe my health condition was. After several phone calls, I received approval to have my teeth removed on my birthday, March 3.

Since March, my health has improved greatly. I will receive my dentures on June 25. The dentures are considered temporary, as they are not the highest quality, although with care, they should last a long time.

Although I feel fortunate to have my husband working at a plant that is exceptional in their attitude toward employees experiencing difficulties due to being unemployed, we are still facing medical bills from 1985 when George was unemployed and did not receive health insurance.

While unemployed, our bills did not decrease, only our income. We did not have the funds for several months to pay for all of my prescriptions and had to rely on friends to lend us the money until we received reimbursement from Blue Cross. At times, the reimbursement did not come for 6 to 8 weeks.

I still must pay for my dentures, and at times, my co-pay for tests for my heart condition have been up to $140. When the doctor indicated I must avoid all stress, he did not explain how this can be done in Flint with my husband's employment being closely related to GM and the unstable work being experienced in Flint.

I am constantly aware that should my husband again experience another lay-off, Shamrock may not be able to provide medical coverage, and my prescriptions have, at times, exceed $110 a month.

Senator RIEGLE. You're doing fine. Just take your time.

Mrs. GILLIAM. I hope that you, Senator Riegle, will be instrumental in insuring that all of us can be assured of affordable medical care during times of unemployment.

Thank you.

Senator RIEGLE. Thank you, and give her a round of applause.

[Whereupon audience applause was given.]

Mrs. GILLIAM. I guess I've been talking a little loud on this microphone, so, I want to talk a little more softly, but it's not easy to come and testify in this fashion, especially when you're waiting for your dentures. I tried to get them before today.

Senator RIEGLE. Well, you did a terrific job, and it was, also, a very well prepared statement. It's very helpful to have that on the record.

I want to indicate right now that we have well over two hundred in attendance. I think, this is a real statement about the importance of this issue to our country. Here it is, mid-morning on a Monday morning, a weekday, and this kind of turnout of people here, I think, shows the great urgency that this matter has, and I want to, again, thank all of you for coming.

When we complete our witnesses, we're going to go to witnesses from the audience. There's one woman I've already spoken to that I've asked to say publicly what she said to me about the problems that she's experiencing.

So, we'll hear from her and others later.

Let me now go to Cora Humphrey. Cora lives with a burden of tremendous bills as a result of a bout that she has had with lung cancer. Mrs. Humphrey is not quite old enough to receive Medicare, and is not quite qualified for Medicaid assistance.

She is going to tell us about her struggles to buy needed medicines, to pay off her bills and still try to take care of basic necessities on what is a very small income.

So, we're very pleased to have you, and when you're ready, we'd like to hear from you.

STATEMENT OF CORA HUMPHREY, FLINT, MI

Mrs. HUMPHREY. Hello, my name is Cora Humphrey. I live in the City of Flint. I owe over $16,000 in medical bills from lung cancer surgery that was done in March 1985. My income is $582 per month.

There is not a month that goes by that I do not receive a phone call or stack of bills to remind me of my medical condition. At the time of my surgery, my now deceased husband, James, applied on my behalf for Medicaid to assist with the hospital and doctor bills.

We were denied Medicaid based on our income and due to my not being considered disabled. James considered himself a proud man, one who did not ask or beg for assistance; thus, he did not understand the Medicaid system, rules, regulations, and paperwork.

After several trips to the D.S.S. office to carry back the information they requested, we received a second denial letter. James was very angry when he went back to the D.S.S. office with the denial letter, as he had done everything the case worker had requested.

The case worker attempted to explain to James how to appeal the denial. At this point, James was very upset and angry because of my serious illness and the mounting doctor bills, that he walked out of the office. I now know that he failed to understand a system that may have assisted.

We raised 10 children and never received any assistance. James worked several years driving and repairing trucks for a local gravel company prior to going to work for Buick in 1972.

In 1974, James had a heart attack and went on disability and later Social Security Disability. We did not receive health benefits

from GM, as James had only worked there 2 years prior to his heart attack.

James was a World War II veteran and received VA Benefits. When James needed prescriptions for his diabetes or heart condition, he went to the VA Hospital. The VA does not provide health coverage for family members.

At the time of my surgery in 1985, I was 61 years of age and too young to receive Social Security based on James' working, and since the surgery was unexpected, I had not applied for Social Security Disability in my own name.

Since James' death, my Social Security is based on his income. However, I still do not have Medicare because I'm not 65, and I can't receive Medicaid unless I incur within a 6-month period, approximately, $1,200 in medical expenses.

At this point in time, I can barely stretch my income to cover my 2 monthly prescriptions and office calls I may need. Every 3 months, I receive a chest X-ray and blood tests to ensure that cancer has not returned.

Due to my limited income, I can't afford to become ill, as I am currently struggling to pay over $16,000 in outstanding medical bills. Since James' death, my income has been reduced by $457.

I am well aware that since Hurley Hospital placed their outstanding bill in the hands of a collection agency, and because Hurley is a city owned hospital, a lien may be placed against my home.

When James was alive, he was constantly worrying which medical bills would be paid each month, as his greatest fear was that a lien would be placed against his home.

James did apply to the Michigan Veterans Trust Fund for assistance to pay my medical bills, but the request was denied as not meeting the criteria of temporary unexpected emergency.

My goal is to remain healthy by taking my medication for high blood pressure and arthritis. At 3 month intervals, I will continue to obtain a chest X-ray and blood tests to monitor the possible reoccurrence of cancer. I will, also, continue to pay on my outstanding medical bills. I will, also, pray that your goal, Senator Riegle, will be to work toward obtaining for all of us, affordable medical care.

I will, also, pray that reforms will be made within the Medicaid system that will provide fair and realistic access for everyone.

I am certain that the stress from constantly worrying about my medical bills contributed significantly to my husband, James, overall ill health and early death.

Thank you.

Senator RIEGLE. Cora, thank you. I know it's not easy to come and tell these personal stories this way, and you do a great service to the country when you do this, and we appreciate it more than I know how to say.

Can you tell me, are there times when you miss going to the doctor when you know you should because you're afraid of the cost?

Mrs. HUMPHREY. Well, I always manage to try to scrape up the money somehow to go because I know it's really necessary to go.

Senator RIEGLE. Yes, yes, and, of course, you have had this serious cancer problem, so, you know you can't afford to take any other risks.

Mrs. HUMPHREY. That's true.

Senator RIEGLE. I take it, though, that this stress that you had felt, that you think maybe even speeded his death, is a stress you feel all the time, yourself, now?

Mrs. HUMPHREY. Yes, I do. I really do.

Senator RIEGLE. Do you think it affects your health?

Mrs. HUMPHREY. Well, I don't know about that.

Senator RIEGLE. It's pretty hard not to, isn't it, when you're always worrying about something?

Mrs. HUMPHREY. I sure am, that's for sure.

Senator RIEGLE. It seems to me that one of the things I hear all of you saying that have spoken, is that the pressure——

Mrs. HUMPHREY. That's right.

Senator RIEGLE. The constant pressure and the fear; the financial fear; the health fear; is something that is there every single minute of the day, whether you're thinking of it in the front of your mind; it's in the back of your mind.

When the bills come, the phone calls come, and you don't feel well, then, you know it constantly comes up to the front of your mind; but I gather this is something that is so pervasive in your lives, that you just can't escape from it; is that correct?

Mrs. HUMPHREY. Yes.

Senator RIEGLE. I see you all nodding in the affirmative.

Well, I'm going to put a question here to the audience and because I think we need to get some expression of what you think. So, that we're in a position to know how best to act on these issues, I'm going to put two or three questions to you now as a large group here.

First of all, I'd like to ask, how many of you here feel that it is time for the Government to act on a national level to enact some program like the one I've been describing here to provide this new and extended health care coverage that can start to meet some of the problems of the kind that we've heard today.

How many of you feel that that is needed and that you would support that kind of initiative? Let me ask you to raise your hands?

[Whereupon the audience complies.]

Senator RIEGLE. A very, very substantial majority.

How many have reservations about it and feel that the Federal Government should not be moving in this area?

[Whereupon the audience complies.]

Senator RIEGLE. I see two, three, four—I see five. I see about five hands go up on that side, so, there are people who do have reservations or opposition to it, but it would be fair to say in terms of the show of hands that we're seeing, that the overwhelming majority of those here do feel that it's needed.

How many of you are prepared, if we have such a plan as that, to accept the proposition that there will have to be an additional financing cost that goes with it, presumably, the increase in the Medicare deduction that you now have of $17.90 a month?

How many of you are prepared to accept that notion with the thought in mind that it should enable you to either discontinue your Medigap policies and save that money, or to scale them way back maybe to meet some particular thing that you have an alarm about.

How many of you are prepared to have that kind of a financing system as the way in which we would get this broader coverage across the whole population? Let me ask you to raise your hands. How many would be in favor of a financing plan along that line?

[Whereupon the audience complies.]

Senator RIEGLE. How many would oppose that and want to see something radically different than that?

[Whereupon the audience complies.]

Senator RIEGLE. I see one, two, three—I see probably eight, ten, twelve hands on the other side. That's a hard question to answer, and it's a hard question for me to put because when we start thinking about how we would undertake to craft a financing system, it's very difficult to figure out how because it's a very expensive need that we're talking about, as we know just from these illustrations.

When the bills start mounting, you can get to above $10,000 very, very quickly with just one serious illness and one extended stay in the hospital.

Well, let me thank all of you, and, I think, we ought to give all of these people maybe a round of applause for coming in and speaking today. [Audience applause.]

Let me thank you, and you're welcome to stay, or you're welcome to leave as you wish at this time; but we are very appreciative of your testimony.

Let us now go to our second panel. Our second panel is made up of health care professionals and experts in the field. They are here to talk about other kinds of problems that arise when people don't have the health care coverage, and they're going to suggest some possible solutions to that.

We'll wait just a moment to let those that are leaving the room make their way out.

I'll introduce our first witness, who will be Mr. Arthur Hughes, who chairs the UAW Region 1C Retiree's Counsel and is the past President of UAC Local 140.

Before he retired, Mr. Hughes was an administrative assistant with Douglas Frazier, Mark Statman, and Norman Matthews. He was a member of the Walter Reuther Study Group on wage replacement, health security, pension programs, and guaranteed annual wage income security plan.

So, he certainly is an expert going back over many years in this area, and, of course, has had the chance to see a wide variety of health situations as they have been experienced by individuals.

I should, also, say before calling on Mr. Hughes, that the UAW is probably the premier labor organization in this country in terms of pioneering in the field of health care coverage and addressing the needs of workers and their families in this area and have crafted in their negotiations over the years, proposals to provide as part of the compensation for the work that is done, health care protections of various sorts that are needed.

So, it's from that background that he speaks. I know you have a lengthy statement, and I'm going to put in the record, and I want you to go ahead and take the time you need to lay it out. We're pleased to have you here today, Mr. Hughes.

STATEMENT OF ARTHUR HUGHES, CHAIRPERSON, UAW REGION 1C RETIREES' COUNCIL

Mr. HUGHES. Thank you, Senator.

I do have quite a lengthy statement. I thought that I would have the time, but, obviously, I don't, to read it; but let me, in summary, make a presentation on two bases: The impact of the unemployment that we are experiencing on health care, as well as the health care problems as they are brought to our attention.

Let me say at the outset, I thank you for the kind words that you've expressed as far as the UAW is concerned.

As a UAW retiree in our retiree organizations, we have a good number of questions that come about, not only from our retired members, but people in the community whom we do not chase away. We welcome, whether they belong to our union or not, the opportunity of servicing to assist where we can on the family problems and in the retiree area.

In regard to the active workers, I think, it's quite important that we understand in the economic financial areas as to where we're at and to where we're coming from.

Before this meeting, it was suggested that I talk about the unemployed in the Flint area, and the information that I have, at least passed on from our General Motors section of the union, there will be 10,000 permanently unemployed with plant closings, plant relocations, and, of course, by the imports and the absence of new controls over the corner market; but I just put together a little bit suggesting the kinds of financial problems that come about as a result of unemployment where people are laid off.

I look at an assembler, an active assembler, and using him as the illustration, the most common classification in the assembly plant as receiving $12 an hour, or $480 a week; and from that weekly paycheck, there is 7.1 percent social security tax, and 7.1 percent of employer tax; and you put those together, that represents $68.06 from both of those that goes, supposedly goes into the social security fund, and seemingly with that amount of money going in from each person, there is a feeling, at least a comfortable feeling, that we do have some input.

Let me take a look at the negative side of it because for every 1,000 unemployed workers, there is $68,000 that does not go into the social security fund to help on social security, as well as the health care.

For 5,000 unemployed, that's $340,000 and for the 10,000, this is $681,000 that does not go into the social security fund, and, of course, if the unemployed continues for a year for the $10,000 that's $35 million that does not go into the social security fund.

When you take a look at that, you can understand why there is a wrestling around about the impact that social security has on Medicare for lack of fund, obviously, and the reason for the excitement in Congress to make decisions and determinations as to the co-pay

and deductibles, and the reason that I did not express support of the question you raise on, am I willing to go along with the idea of the co-pays, the deductibles, and, now, what you say, the 1,700 to 2,000 since social security was enacted in 1965.

There has been a gradual increase in the co-pay. There's been a gradual increase in the out-of-pocket expenses, and I just cannot see that we ought to say to the retired workers, or the retired workers' families, that we expect from you all of these additions, the $2.40 increase that came about at the beginning of this year.

Now, we're asking you to pay nearly $2,000 as co-pay. I don't think the co-pay has any impact on cost containment that we're trying to get at in social security, as well as the other health care areas.

So, as a result, I think it brings on the catastrophic problem, that is a shortcoming in the social security program. There is a prescription drug program that's a shortcoming in that area.

Instead of adding these programs as a necessity with the money that otherwise would have been put in the fund, we are asking for these additional payments that the commercial underwriters are not going to get but are, obviously, going into the social security program.

The thing that bothers us and quite a noise is that many of our counterparts who are arguing against the idea of social security, the pension program, are the same people, the same organizations, that are getting more consideration, financial consideration, than the ordinary John Doe who is responsible for that organization being in business; and why do I say that?

One of the large corporations that supposedly is back on its feet now, and gets a lot of ballyhoo on it came back to life because there was $1.5 billion in tax credits; money that comes from the individual John Doe who pays the taxes, given to that corporation, helping that corporation get back on its feet; and without that $1.5 billion, I don't know what would have happened.

I think in a competitive field as we talk imports and the foreign trade and the like of that, I think this organization could have survived and this corporation, in surviving, would have had larger employment than it currently survived with, and as a result of that, the monies that flowed to the social security fund and that part that has been marked for the—for the health care benefit.

I raised an objection, too, because I don't agree with Mr. Bowen. I don't agree with the President of the United States. I did get an answer from you on the letter that I had sent in regards to my position and of my attitude as far as the current bill is concerned because, again, let me repeat.

There is an increase in the social security premium for Medicare, Part A and Part B. In addition to it, there's an increase on the co-pay on the deductible, and what I generally refer them to, as you have on your chart, these are out-of-pocket liabilities that are imposed upon people who should not be paying these benefits.

Then, I look in the paper, in this morning's paper, I see, oh, this fella—this minister, Bakker, or whatever it is, that he now, after receiving millions or billions of dollars, I suppose over his term of life, is allowed under the bankruptcy law, to file for bankruptcy for his organization; and what happens in bankruptcy?

Most of them, bankruptcy filing, result in people—businesses, making money rather than losing money, and where does the money come from to begin with?

The taxes of the John Doe's—people, and, I think, it's quite important we begin realizing that social security that began in 1965, began with a $50 deductible co-pay.

Now, it's $520. You got to pay the up front money, and that's a very substantial increase, and what bothers me, and I'm referring to the $50 in 1965 up to $520 now, we are beginning to get into the habit of increasing rather than trying to level off the experiences that the ordinary John Doe citizen is having.

That is why do we continue to insist that we get more co-pay, more deductibles; some other countries have National health insurances. I might say that the late Walter Reuther, in his time, was very aggressive and was very outward about a National health insurance program, and, I think, the sooner we get on a national health insurance scale as other countries around the world are having, I think, then, we will talk about meeting the needs of all of America.

I think, we ought to get America back to work because with the absence of the tariff laws, with the absence of quotas, and the absences of other laws that we really need, we are having the foreign market robbed.

We're having the foreign market rob us of the opportunities that we ought to have. Now, I don't only want to talk about auto. I wrote a letter just recently to the Agricultural Secretary and I said to him, "I understand that there's a good bit of corn being imported from Japan and the United States," and what did he say?

He said, "As of June 9, estimate of corn imports from Japan in 1987, 1988, is 16.2 million metric tons, up from 15.8 million tons in 1986, 1987."

So, we are being pacted as a country that is enforcing and supporting many of the economic needs of other countries. I don't quarrel with that, but, I think, we have an obligation and responsibility to our own people.

Then, I read in the paper, and people think nothing of it, $100 million to the contras, $100 million to this country, $100 million to that; and I would smile at reading the newspaper if I thought that $100 million was helping to build on the social security fund and the needs—the health care needs—of the people in this country.

So, I think, there's an important job and responsibility as far as Congress is concerned, as far as the President is concerned. Let me say for the retirees, you know, I don't want to get into senility, but sometimes it's hard to say; but 2 years ago, or 3 years ago, we read in the newspaper one of the candidates for the President of the United States said that, "There will be no tax on senior citizens. We will protect the integrity of the Social Security system." Well, we are not getting either one of those commitments or promises that were made by that candidate at that time.

If you look at the record, senility has crept into it. He can't remember last week, let alone a couple of years back because when you say you won't tax social security, we won't tax the elderly, but the elderly are now being taxed under that program, we are really

being disfranchised in the sense that promises were made to us, and promises made are promises not kept.

There is much more that can be said in this area, but let me just close with what I think are some of the solutions. I think, one of the solutions is to get more money and the Government spending, is to change the tax laws.

Why should we protect the business man only to the extent that we allow him to tax credits? Why don't we have tax credits for ordinary John Doe citizens? I think, this is quite important to reorganize our whole tax structure, so that there's a better balance.

Should business be the only one that get the financial support of the Federal Government? I think not. I think the people responsible for those businesses being ongoing organizations deserve some attention from the Federal Government.

As I said at the outset, I had a good bit of notes that we will leave for your record, but I think it's quite important that the Congress pays attention to reducing, and I don't quarrel with your question to get a feeling and a sentiment of the people as to whether or not they believe that we ought to be increasing the co-pay to take care of an immediate problem.

I think, taking care of the immediate problem is government at work for the interest of the people that that government should represent. I don't say this to you because I know your record is good; but I say this to the other people in Congress. Get back with America and begin serving the American people. [Audience applause.]

Senator RIEGLE. Thank you.

[The prepared statement of Mr. Hughes follows:]

PREPARED STATEMENT OF ARTHUR HUGHES, CHAIRPERSON, UAW REGION 1C RETIREES' COUNCIL

I am privileged with this opportunity to address our Michigan Senator, Don Riegle, who serves on the Senate Finance Committee having jurisdiction over many important areas affecting the economic security of America including Social Security and Medicare.

There are varied opinions as to the solvency of Social Security and Medicare for Seniors and the American work force. There was a shadow of gloom from the Grace Committee which many believed would be the doom of Social Security. Then there is the more reliable and heartening report from the Social Security Board of Trustees. This later committee in its annual 1986 report gave the monthly benefit S.S. Program a clean bill of health for the next 75 years.

Although encouraged by the S.S. Board of trustees 1986 report, active workers and beneficiaries of S.S. became excited and concerned about the impact the loss of American jobs, the unemployed will have on funding Social Security and Medicare.

It prompts the often repeated question "Will I ever be a beneficiary of Social Security?"

The beneficiaries of S.S. and Medicare share this concern with the active or younger work force and their families as to the solvency of both Social Security and health services; the continuation of Medicare, of a comprehensive non-contributory health care program, during permanent and sporadic unemployment periods.

The UAW will continue to pursue the ideals and goals of Walter Reuther initiated for national health insurance. Until such goals are realized, the UAW's pursuit of NHI will continue under intermittent programs.

In the Flint area, from information we have from General Motors, there will be nearly 10,000 unemployed by December 1987. The layoffs are attributed to plant closings; mostly the effects of trade imbalances—really the Administration's "failed trade policies" and the trend of domestic automakers becoming importers of parts and vehicles.

The benefit plans or wage replacement programs negotiated by the UAW, will at most serve as a cushion for the laid off workers. There is no semblance of long term wage replacement except for those qualifying for private pension plan benefits and who may possibly have continuing health care insurance. Even then, the pension plan benefits will represent about 50% of lost wages.

State unemployment and supplemental unemployment benefits are temporary. Continuing health insurance is controlled or related to the term of SUB eligibility.

Eligibility and duration of health care services are geared to an active worker's accumulated credits under the Supplemental Unemployment Benefit Plan. Under the SUB plan an active worker may earn 52 credits for health care coverage for up to 12 months of continuous layoff. Four credits are traded for a month of health care coverage. A worker may earn new credits upon recall from a layoff to build up to the maximum 52 credits.

Credits may be spent at a faster rate if the SUB fund falls below certain levels and the laid off worker has less than 25 years service.

Job opportunities with G.M. or recall to a G.M. plant are quite remote.

The 10,000 G.M. workers who will lose their jobs, not of their own choosing, will exhaust their health insurance benefits, adding to the insecurity of the worker and family. 10,000 workers will be without jobs and left to exhaust securities of their entitlements of the collective bargaining agreement.

The Social Security Program will suffer from the loss of income the 10,000 workers would be taxed and credited to the funding of Social Security.

The budget deficit, the trade deficit, more than suggest a turn around of economic planning to keep America alive with full employment and the financial ability to purchase American made goods and to provide comprehensive health care for a healthy America. We cannot survive alone with a dependence on manufacturing goods. Farms are closing because of America's disconcern toward their needs and the imports of farm products.

Owen Bieber has urged Congress to enact legislation to stem the mounting national trade deficit for a trade policy to protect U.S. employment, production and income. Bieber has warned that the deteriorating trade imbalance affects "nearly all sectors of the U.S. Economy; agriculture and high technology industries. Millions of unemployed and underemployed Americans and thousands of depressed communities suffer from employment cutbacks, plant closings and plant relocations with employment cutbacks. Workers with equities in private pension plans are encouraged to retire to reduce the number of unemployed.

The corporations who encourage early retirement then complain about the cost of their pension and health insurance obligations.

With the increase in the number of Medicare beneficiaries the government, Congress is awakened to additional projected costs factors.

The impact from high levels of unemployment hits at lower federal income from general taxes and lower federal income to finance Social Security, Medicare and Medicaid plans. Unemployment is a threat to the solvency of income security and health care programs.

The Social Security program loses *7.1%* of weekly wages from each unemployed worker and a similar amount from the employer, or approximately an average of $67.20 weekly.

Unemployed workers lose credits toward their private pension plan and lessen the value of retirement income.

There have been adjustments in the Social Security-Medicare programs transferring costs liabilities to recipients (retirees).

The January 1987 premium for Medicare Part "B" was increased by $2.40, raising the monthly premium from $15.50 to $17.90. There was also an increase in co-pay and deductible, out of pocket cost, for Part "A", increasing co-pay to $520. Incidentally, the Part "A" co-pay began with *$50 in 1965* and to date is *$520.00*.

This later scheme for transferring costs to senior citizens, beneficiaries of Social Security and Medicare is in effect a means test.

The newly considered legislative measures will require additional out-of-pocket costs of about $2000 annually before Medicare trickles in. Thsi supposedly is an answer to catastrophic illness care.

Then there are ideas to increase premiums for Part "B" Medicare geared to income.

Means testing is not a solution to costs for medical services, nor are co-pays.

They are simply plans or programs to transfer costs to those with budgeted incomes. Out-of-pocket costs should not be a substitute for accountability or means testing.

Millions of Americans have no basic health insurance. Understandably, to extend or improve health care security for a comprehensive program, up front costs may be necessary.

Medicare falls short in a number of important services such as custodial care, long term illness, prescription drugs, and additionally many doctors will not accept Medicare assignments.

National health insurance, with accountability, is long overdue in America. A program to keep America healthy should be an essential ingredient to the American way of life.

Legislative action to secure income for Social Security is needed to keep American workers on the job. Appropriate *tariff* legislation quotas are necessary as controls over imports to assure greater employment as job content, etc. Imposing penalties on corporations who spend American earned dollars on foreign trade may be an incentive to keep jobs at home for full employment.

Senator RIEGLE. Thank you. I'm going to want to come back and discuss with you some of the important points that you raised, but I now have to call on Mr. Edward Connors, who has a bit of a time problem. He is here today as the President of Mercy Health Services.

Mr. Connors has been involved in health care management for over 30 years and is a very respected professional in the health care field. Mercy Health Services is the parent organization in a number of organizations which form a major not-for-profit health care system in this country.

Mr. Connors, we're very pleased to have you. We'd like to hear your thoughts at this time.

STATEMENT OF EDWARD J. CONNORS, PRESIDENT, MERCY HEALTH SERVICES

Mr. CONNORS. Thank you. As you indicated, I am here as the President and Chief Executive Officer of Mercy Health Services, a not for profit, religiously sponsored organization, and my remarks today are intended to convey the seriousness and the widespread nature of the lack of adequate health care benefits as we experience it.

I want to comment very briefly to augment the written testimony on the three specific proposals that are currently before Congress in addressing the problem.

The S. 1265 recently introduced by Senators Kennedy and Weicker, your own Senate Bill 177, and the Medicare Catastrophic Prevention Bill, which you mentioned in your opening remarks.

The Sisters of Mercy have served here in the State of Michigan since 1879. We have made a permanent commitment and a permanent presence to try to serve and provide quality health services to all in the—we, currently serve in a variety of communities from the inner city of Detroit to rural Iowa.

Our services include the States of Indiana and Iowa and parts of New York. Here in Michigan, we have hospital operations in Grayling, Cadillac, Muskegon, Grand Rapids, Battle Creek, Lansing, Ann Arbor, several facilities in Detroit, Pontiac, and Port Huron.

In addition, we have gotten into the provision directly of home health services, skilled nursing facilities, and a modest start in housing facilities for the aged citizens.

I say this not to impress you with size or complexity but to note that your commitment is significant and our experience, we be-

lieve, is relevant; and, also, to note that we are, also, a major employer in this State and in the community; that we serve some eighteen thousand employees, and if you had the families of those employees responsibility that we feel deeply for some 35,000 to 38,000 thousand people as an employer.

I'm gratified that Congress, and thanks to your leadership, Senator, is beginning to seriously deliberate what should and what might be done in this complex time to arrest the decline of Americans with no adequate health insurance.

You know the study. You know the figures. Your introductory remarks indicated that you and your staff are well informed on those figures; but size of the uninsured population is about 37 million.

Governor Blanchard indicated in his remarks in the State of the State message in 1987 that 900,000 to 1 million citizens here in Michigan have no health insurance.

When we consider mandating health insurance coverage because that's the major consideration of the Kennedy-Weicker bill, mandating health insurance coverage, I think, we have to realize that here in Michigan we have demonstrated our commitment to the residents in some other ways for adequate health insurance.

I would cite the required automobile insurance for all drivers, which must include coverage as a result of the injuries suffered in automobile accidents. I cite that as an example where there is precedent of mandating coverage and insurance because of a social need.

To make a long story short, it's my understanding that because of the way in which benefits have been interpreted under the Federal Employee Retirement in some income security act, Michigan is prohibited right now as a State from mandatory minimum benefits for self-insured health programs, or even from requiring employers to provide minimum health care benefits for their employees and their families.

I don't understand why, but that's what I'm told; thus, I strongly urge, and my organization and my organization urges, a Federal mandate requiring that employers provide minimum health care benefits for their employees and their families.

While Senate Bill 1260 will not—1265 will not provide universal access to needed health care benefits for all of the thirty-seven million, it could fulfill the promise of access for health care to nearly two-thirds of the persons who are employed and their families who do not now have access to employer sponsored health coverage.

I say that because of what we—and I believe about health care, and that is that all persons have an inherent right to needed health and medical care, and that it's up to the public and private sector together to see to it that this fundamental right is not abrogated in the way we organize finance and deliver health care to people.

Now, most of the people that come to our institutions fully intend to pay for their care. If you heard the stories of this morning, as hospitals, we try to be as flexible as we can to work out reasonable payment and schedules for such people and for such care, particularly those persons who are employed, are temporarily unemployed with no or inadequate health insurance.

There is a growing problem to people unable to pay, and that growing problem is reflected in our own significant increase and bad debts.

In this State alone, the bad debts of our institution is over $26 million a year. It's three and a half times the amount that it was in 1980. This increase has incurred in all of our facilities not limited to hospitals that are in geographic locations that have traditionally thought to be of unstable unemployment or low-waged jobs.

These increases have come about, despite what we believe, effective and human efforts to take all appropriate steps to assure ourselves that those who can pay, do pay; thus, we are caught in a very anguishing bind, and as we continue to serve the poor and uninsured and our bad debts and charity load is rising, we have, thus, fewer and fewer resources to keep our facilities and our equipment current with medical science and to develop services outside the acute patient setting.

The concepts embodied in Senate Bill 1265 are important. They are deserving of support. It provides a maximum out-of-pocket expenditure. One might argue about the amounts, but the maximum is there. It emphasizes the importance of preventative care. It promotes the prudent use of hospital services because of the cost of health care in this country.

The problem has not been in efficiency, it's been use. It encourages the development of manage care systems, which is an important element, and it recognizes the rights and needs of individual employers and employees to respective collective bargaining process. There is some flexibility in the way it might be accomplished.

Well, I realize that mandated benefits will cost employers more money, and, thus, an increase in the cost of goods and services. Then unmet and inadequately met health care needs of many employed individuals and their families create an imperative that cries out forthright and persuasive solution. We must face those additional costs.

Now, while the mandate of employer's health care coverage will close a large portion of the inaccessibility gap, it will not close it entirely, as you have indicated; thus, your own bill of Senate 177, the health care for the uninsured act, could provide an additional way in which individuals with adequate means would be able to purchase adequate health care coverage benefits for themselves and their families.

Such as I view it, it is a way to complement the health care benefit mandates of Senate Bill 1265 and, potentially, provide for an option for the some 12 million individuals who still would not have access to mandate health care benefits, and we consider tools, we should look, I think, at the experience of other states, and fashion that sensibly and complementary to the mandated benefits.

Clearly, our society must find the solution to enabling citizens to receive care when it is needed and for providers of care to be paid for that care. Now, time does not permit a discussion of the growing demand and need for charity care.

This is covered in my written testimony to you. Let me merely say in my own experience here in Michigan, our hospitals collectively provided $7.5 million of free charity care, or last year; more than double the amount that we did in 1980; and those are not

amounts included in our bad debt numbers that I mentioned to you earlier.

Let me compliment the work today on the Senate Finance Committee on the Medicare Catastrophic loss prevention act. If passed and finalized, I believe, this bill will help to provide some of the needed security to the millions of Medicare beneficiaries. So, their savings would not be completely eroded in order to pay for bills arising from needed health care.

I believe, that the progressive, premium funding charge is desirable, but I realize, as you do, that Senate Bill 1127 still leaves unresolved how individuals can secure their needs for long-term care and other potentially catastrophic health care needs, and particularly, in my opinion, the bill does not adequately cover three critical areas of senior citizens' needs; nursing home care, home health care, and prescription drugs are detailed comments on this bill, were provided to you earlier this month at the hearing in Warren, and, I think, it's in the right track.

Let me thank you, Senator, for providing me and my organization with this opportunity to explain our views on these matters. Mercy Health Services stands ready to work with you and your colleagues developing and implementing appropriate solutions to the access problem, and I would be pleased to respond to any questions you may have. [Audience applause.]

Senator RIEGLE. Thank you, again, for the excellent testimony.

[The prepared statement of Mr. Connors follows:]

PREPARED STATEMENT OF EDWARD J. CONNORS, PRESIDENT,
MERCY HEALTH SERVICES

INTRODUCTION

Senator Riegle, I am Edward J. Connors, President of Mercy Health Services, a voluntary not-for-profit provider of health care services sponsored by the Religious Sisters of Mercy, Province of Detroit. My remarks today are intended to convey the seriousness and widespread nature of the lack of adequate health care benefits on the part of 37 million people in this Country. I will also comment on three specific Senate proposals aimed at addressing the problem: S 1265, the Minimum Health Benefits for All Workers Act of 1987, recently introduced by Senators Kennedy and Weicker; your own S 177, the Health Care for the Uninsured Act; and S 1127, the Medicare Catastrophic Loss Prevention Act of 1987.

Since 1879, when the Sisters of Mercy commenced operations of its first hospital in Big Rapids, we have committed ourselves to providing a permanent Christian healing ministry, which has since expanded into the neighboring State of Indiana, as well as into Iowa and New York. Our ministry currently extends from the inner City of Detroit to rural Iowa, and there are an estimated 5.4 million people in our service areas.

Our origins are hospital-based acute care and our system includes about 5,700 acute care beds. In Michigan, we own and operate hospitals in Ann Arbor (Catherine McAuley Health Center and St. Joseph Mercy); Battle Creek (Leila); Cadillac (Mercy); Detroit (Mt. Carmel Mercy and Samaritan Health Center); Grand Rapids (Saint Mary's); Grayling (Mercy); Lansing (St. Lawrence);

Muskegon (Mercy); Pontiac (St. Joseph Mercy); and Port Huron (Mercy). To respond to contemporary health care needs, we have diversified beyond our hospital origins into home health care services, long-term care facilities that serve the continuum of care needs of the elderly, and health maintenance organizations. In addition, we have extended our service capability into jurisdictions outside the United States.

ACCESS TO HEALTH CARE COVERAGE BY THE WORKING-AGE POPULATION

I am pleased that you have created this opportunity for me to provide my perspective on health care availability issues. As you may be aware, I testified in March before the Subcommittee on Health of the Committee on Ways and Means of the U.S. House of Representatives regarding the surging demand for hospitals to provide health care services to those without any means of providing reimbursement for the care rendered. Subsequent to that appearance, Senators Kennedy and Weicker have introduced S 1265, the Minimum Health Benefits for All Workers Act, which would provide a minimum benefit mandate for health care coverage for just about all employed individuals.

I am gratified that the Congress is beginning to seriously deliberate on what should be done to arrest the decline in the proportion of American workers with basic health insurance coverage. The American Hospital and Catholic Health Associations have both issued studies and recommendations in 1986 which address this and related problems of access to health care. The American Hospital Association's publication, Cost and Compassion: Recommendations for Avoiding a Crisis in Care for the Medically Indigent

defined the appropriate responsibilities for hospitals, various units of government, and employers in meeting this problem. The Catholic Health Association's publication, No Room in the Marketplace: The Health Care of the Poor, outlined appropriate responses for government and those involved in the Catholic health ministry. I had the opportunity to participate in the deliberations leading to the publication of both of these documents. I commend them to you as excellent perspectives on this problem.

Governor Blanchard in his 1987 State of the State message to the Michigan Legislature stressed that there were "[m]ore than 900,000 Michigan citizens [who] lack any public or private health care insurance whatsoever," and that "[o]f these nearly one million people more than three-fourths are dependents of workers or are the 'working poor.'" Governor Blanchard is committed to forming a task force to examine this issue and potential options available to solving this problem within the State of Michigan.

Michigan has demonstrated its commitment that its residents have adequate health care coverage benefits in a number of ways. Our State's statutes require automobile insurance for all drivers which must include coverage for all necessary medical treatment and rehabilitation service required as a result of injuries suffered in automobile accidents. In addition, Michigan has mandated certain coverage provisions in health insurance products, such as substance abuse benefits, and now pending in the Legislature is, a requirement for coverage for Alzheimers disease. However, a greater and greater percentage of businesses providing health care benefits to employers - even small businesses - are self-funding them, and because of Court interpretation of the federal Employee Retirement Income Security Act of

1974, or ERISA, and its provisions pre-empting certain State actions, Michigan is prohibited from mandatory minimum benefits in self-funded programs, or even from requiring employers to provide minimum health care benefits for their employees and families.

S 1265 would bypass both the ERISA pre-emption problem and the patchwork quilt of state health insurance benefit mandates by defining a minimum health care benefit package that must be provided to all employees and their families, whether they reside in Maine or California. Mercy Health Services is, itself, a multistate employer, and we see no reason why our employees in Iowa or Indiana should be governed by a different minimum benefit standard than our employees in Michigan.

S 1265 EMPLOYEE BENEFIT MANDATE

I strongly support a federal mandate requiring that employers provide minimum health care benefits for their employees and their families.

While S 1265 will not provide universal access to needed health care benefits for all of the estimated 37 million uninsured, it would fulfill the promise of access to needed health care benefits for over two-thirds of them: persons who are employed, and their families, who do not have access to an employer-sponsored group health plan. While estimates of the growth in the population of the working uninsured vary, all suggest that this population has increased substantially since 1980.

Most people in need of health care services who come to our hospitals seeking it fully intend to pay for it. We try to be as flexible as possible to work out reasonable payment schedules. This includes persons who are employed, or temporarily unemployed. However, individuals without health care coverage, even those who are employed, tend not to seek health care services unless they can no longer delay treatment, which often means much more extensive hospitalization services in the end, and an extremely high indebtedness to the hospital.

These phenomena are reflected in our recent experience as an unrelenting surge in bad debts which, in our Michigan hospital divisions, totalled over $26 million in 1986, about three and one-half times the magnitude realized in 1980. This increase in bad debts occurred in all our divisions and was not limited to hospitals in geographic locations traditionally thought to be areas of unstable employment and low-wage jobs. For example, bad debts increased over four fold at St. Joseph Mercy and Leila Hospitals in Ann Arbor and Battle Creek, respectively, during this period.

These increases in bad debts have occurred despite our enhanced efforts to take all appropriate management steps to assure ourselves that those with means are paying their bills to our hospitals. There are limits to our being able to absorb more and more bad debts. Systemwide, net income from our hospital operations totalled $12.1 million in 1986, and our complement of bad debts was over two and one-half times our operating income. Thus, we are caught in an anguishing bind; as we continue to serve the poor and uninsured

and our bad debts rise, we do not have the resources to keep our facilities and equipment current with the great advances in medical science and technology, and therefore, to provide the quality of health services our patients must get.

Let me identify some of the important concepts embodied in S 1265 which are particularly helpful in addressing the problem of lack of access to appropriate health care coverage for employed individuals and their families: (1) It recognizes, by providing for a maximum out-of-pocket expenditure of $3,000 for covered services, that protections against catastrophic medical costs expenditures are essential. (2) It emphasizes the importance of preventive care by foreclosing the imposition of a 20 percent copayment on prenatal, well-baby, and child preventive care. (3) It promotes the prudent use of health care services by permitting the assessment of copay surcharges for employees that do not, for example, adhere to strictures for mandatory second opinions for certain surgical procedures. (4) It encourages the development of managed care systems by assessing higher deductibles (set at $250 for an individual and $500 for a family) on those choosing to use services outside a preferred provider organization network that may be set up. (5) It recognizes the individual needs of employers and employees and respects the collective bargaining process by permitting alternative actuarially equivalent plans to the statutorily-mandated minimum benefits. Other salutary features can be enumerated, but the aforecited indicates that employers would, under this law, have wide latitude in designing their benefits and constructing appropriate incentives and disincentives.

I realize that health insurance actuaries have estimated the average annual cost of S 1265's relatively modest benefit program to be close to $650 for an individual and $1,650 for a family and that these amounts represent, de facto, an increase in wages. However, the unmet and inadequately met health care needs of many employed individuals and their families create an imperative that cries out for a forthright and pervasive solution. As a number of other organizations, such as the American Hospital Association, have already pointed out, this added cost to employers may create inequities and other complementary legislation will probably be needed to even them out. Suggestions have included modifications and incentives to the federal tax system to assure that the financing of health care benefits is equitable among all employers.

However, incentives and disincentives are not adequate, in and of themselves, to assure a meaningful increase in the access to health care for the employed population. As you are well aware, the Federal Government already provides over $35 billion in incentives for employers to provide health care coverage in the form of tax deductions, yet the demands for uncompensated care still grow. Further, current financial pressures on the public and the voluntary not-for-profit hospitals resulting from mounting bad debts and each payer demanding and negotiating payment rates that foreclose subsidization of health care for the poor make it essential that employers be mandated to provide minimal coverage for its employees and their families. With the adequate coverage for health care benefits, to which the enactment of S 1265 would contribute, voluntary nonprofit and public hospitals can continue to meet their commitment to provide charity care to the poor.

ACCESS TO HEALTH CARE COVERAGE BY THOSE NOT COVERED BY PROVISIONS IN S 1265

While S 1265's mandate that employers provide health care coverage benefits to employees will close a large portion of the inaccessibility gap, it will not close it entirely. Thus, even if S 1265 becomes law there will still be individuals who: (1) are self-employed and have the means to pay for health care coverage, yet are unable to buy health insurance in the private insurance market even if they or all of their family members are in good health, because most private sector insurers avoid the individual health care coverage market; (2) work a full week, but for two or more employers and not enough hours for any one of them, so that no employer is required to provide him or her with health care coverage benefits; (3) are not working and still have money to purchase insurance in the private market but whose particular health conditions or status, such as a heart problem or diabetes, make them an unacceptable risk to any insurer or managed care system; and (4) are not working and do not have the financial means to purchase insurance on an individual basis.

Hence, while many of these individuals with health care accessibility problems have low incomes, some do not. Therefore additional options intended to enhance accessibility to health care for them must incorporate the diversity of their financial and health status.

S 177 AND ALTERNATIVES TO MEETING HEALTH CARE NEEDS OF THE POOR AND THOSE WHO ARE UNINSURABLE

I believe that many of the features incorporated into your S 177, the Health Care for the Uninsured Act, could provide a way by which individuals with adequate means would be able to purchase adequate health care coverage benefits for themselves and their families. As such, it may be one way to complement the health care benefit mandates of S 1265 and potentially provide an option for a small portion of the over 12 million individuals who still would not have access to health care coverage benefits. As we consider a national program of this nature, we should analyze the experience derived from the several states which already have operational health care pools.

In addition to the state health care pools proposed in S 177, I believe other options consistent with the diversity of the hospital population within each state are equally worth consideration. States can also implement powerful and equitable incentives through their certificate of need requirements, health care benefits programs, and tax laws that may provide alternatives to serve the objective of encouraging the provision of indigent care.

I would like to provide you with an overview of our way for providing charity care in our system. We are deeply committed to this mission and I believe a provision for such services will always be needed. Each of the hospital divisions within the Sisters of Mercy Health Corporation annually pre-budgets an amount dedicated to providing charity care in the upcoming year to the poor needing hospital care.

Individuals to whom we provide charity care are generally those with low or no incomes and who are not eligible for any publicly-funded health care services. The annual amount we have budgeted has been substantial, but it has been within our financial means and tailored to meet the needs of the communities in which we serve. In 1986, our Michigan hospital divisions collectively provided $7.5 million in charity care, more than double the amount provided in 1980. Throughout our entire system, charity care equalled two-thirds our our $12.1 million total net income from operations. I would stress that these amounts are in addition to our bad debt complement I previously discussed.

Undoubtedly our increase in charity care over this six-year period is related to, among other things, the fact that the percent of individuals and families needing this care has increased substantially. In 1982, for example, 72 percent of poor families and individuals in Michigan were eligible for Medicaid, well above the national average of 45 percent. However, the amounts currently provided to our hospitals under Michigan's Medicaid rates are well below our costs, which contributes to our financial pressures.

ACCESS TO HEALTH CARE BY THE MEDICARE POPULATION

Let me compliment you and your colleagues on the Senate Finance Committee for approval of S 1127, the Medicare Catastrophic Loss Prevention Act of 1987. If passed, I believe that this bill would help to provide some of the needed security to millions of Medicare beneficiaries so their savings would not be completely eroded in order to pay bills arising from prolonged

hospital stays and extraordinary medical charges. I believe that the progressive premium funding charge is highly desirable but I realize, as you do, that S 1127 still leaves unresolved how individuals can secure their needs for long-term care and other potentially catastrophic health care needs. In particular, the bill does not adequately cover three critical needs of senior citizens: Nursing Home Care, Home Health Care, and Prescriptions. Our detailed comments on this bill were provided to you earlier this month at your Hearing in Warren and we also offer to work with you in shaping the details of its coverage provisions.

CONCLUSION

Let me thank you for providing me with this opportunity to explain my views on these issues. I stand ready to work with you and your colleagues in crafting appropriate solutions to the access problem and I would be pleased to respond to any questions you may have.

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Senator RIEGLE. I might just say one thing about finding the way to pay these bills before we call on our last panel witness, and, then, shortly thereafter we'll take witnesses from the audience who have asked to speak. In this question of finding the way to pay the bills, and that's been raised by Mr. Hughes and others here today.

There is a proposal before the country right now to go ahead full blast, with the Star Wars Program. Star Wars will cost this country $1 trillion, $1trillion—a thousand billion is a trillion dollars—to build the Star Wars system.

I'm not going to get into all the ins and outs of it here. I've spoken out on it before. I think, it's the wrong idea. I think, it's the wrong way to spend the money, but for those who say we can't afford to meet the health care needs of the country, the whole concept behind Star Wars is to try to, presumably, protect the health of the American people in a different way, even if it's something that doesn't make a lot of sense.

If that's the purpose, what's more directly important in protecting the health of the American people than making sure that if they're sick, they have a chance to get well.

It seems to me that if what we want to do is really see to it that our people have a chance to remain well and healthy, and starting with their individual health care requirements throughout the family is right dead center in the heart of that issue.

So, however we end up finding a way to try to finance that kind of a program, I would assert that we have the resources to do it. We have the resources to do it. It's more a question of whether or not we want to attach a high enough priority in our society to say that the health and financial security of our people come ahead of certain other things, and that really is the fundamental issue.

In terms of the bills that we're considering now, this administration and this President has said that they're willing to have a broadening of catastrophic health insurance coverage, but only if the people who get the coverage will pay the bill directly by one means or another, and by putting in those terms, he has, in effect, said, "You try to do it any other way, and I won't sign it into law."

The President has a lot of power that way. Because the Congress can pass a bill, it doesn't mean anything if the President doesn't sign it. He's got to sign it to make a law, and if he doesn't sign it, or turns it down, then, we have to have a two thirds vote to make it law, and that's very, very hard to do.

So, any President at any time has tremendous leverage on the process in terms of defining how it can be done. But having said all that, in 16½ months, we're going to have a new President in this country. I don't know who it will be, or what party he'll be in, but we're going to be dealing with a changed set of facts there.

One of the things that we can do if we want to have a broad, strong National health care program is to see to it that we nominate candidates in both parties and end up electing a new President who is committed to that goal.

If we do that, we could have a President out there leading the effort to try to get a comprehensive plan put together that would meet some of these needs directly.

So, those are some of the factors that bear on our ability on this particular moment to try to move ahead in this area.

Having said that, let me now move to our final panel witness, and we're delighted to have her. She is Judith Clevey, who is the President of the Hospital Counsel of East Central Michigan.

She is, also, here representing the Greater Flint Hospital Assembly. Miss Clevey is a committed health care professional and serves as an adjunct professor at Western and Central Michigan Universities and their health care administration masters program. We're delighted to have you and would like to hear from you at this time.

STATEMENT OF JUDITH CLEVEY, PRESIDENT, HOSPITAL COUNCIL OF EAST CENTRAL MICHIGAN

Miss CLEVEY. Again, thank you, for allowing me to speak on behalf of the thirty hospitals in the East Central Michigan and Flint area. I'm going to divide my testimony into three distinct parts.

First, the cost of care or the cost of providing care to the uninsured and underinsured, what happens when the hospital has to go bankrupt because it has a large burden of under or uninsured, and what we think needs to be done.

First of all, the cost of providing care for those who could not pay for the 22 hospitals in the East Central Michigan area in 1986 was $11 million. The eight hospitals in the Flint area provided $9 million of free care during the same time period.

Senator RIEGLE. Let me get that for the record. The hospitals in the Flint area provided $9 million worth of free care over what time period, now?

Miss CLEVEY. For 1986.

Senator RIEGLE. For just 1986, just last year, right here in this area?

Miss CLEVEY. That's correct. That was three times higher than it was in 1980.

This financial loss does not represent the truly dire situation hospitals faced during the same period with the decrease in Medicare and Medicaid funds. Many hospitals in our area were receiving an average 80 cents for every dollar of care given to a Medicaid patients. Changes in the way Medicare pays hospitals has dramatically hurt the rural and inner-city hospitals.

In addition, in a true economic sense, the continued financial drain on hospitals as a result of providing free care and care at less than cost is significant.

In the East Central Michigan and Flint area, hospitals are the second largest employer.

The area is already reeling from the closure of the auto and auto-related plants. We need to protect viable employers such as our hospitals.

We've talked about the economic impact, but the impact on a family that cannot receive health care because of lack of or inadequate insurance is devastating. I know that we will hear later in the hearing about individuals that could not get care.

Let me state that it is unconscionable that we in this country are more concerned with weapons systems that do not work or are over budget than with the health care of our citizens.

Let's now discuss what can happen when the costs of providing care to the medically indigent becomes too much of a burden on one hospital. On October 6, 1986, Saginaw Osteopathic Hospital closed, and in so doing, left 200 people out of work, but, perhaps, more importantly, left a large segment of the population without access to care.

Saginaw Osteopathic Hospital through the years had become the hospital which served a large number of the uninsured. The costs of this care, approximately 15 percent of their budget, below payment rates of Medicare and Medicaid and the high cost of medical malpractice insurance conspired to cause Saginaw Osteopathic to declare bankruptcy.

I am pleased that the hospitals in Saginaw have risen to the challenge of serving those persons who had an allegiance to Saginaw Osteopathic Hospital, but the cost of providing additional free care will ultimately severely impact those hospitals, as well.

Medical indingence is not a single or simple problem, and the dimensions of this view have already been described by your staff, and, so, I will not restate it; but let me stress that this population is aging and aging rapidly.

By the year 2000, those over 85 years of age will be the fastest growing age group in this country. Those over 85 years of age use hospital care at a rate of twelve times that of those under 45 years of age.

So, we are facing not only a significant problem now, but an even more significant problem in the future if we do not address this. What should we do about the crisis of care for the medically indigent?

First, we should expand both private insurance options and public sector programs. It will require the cooperation of government, employers, providing insurers, and the uninsured themselves.

Fifty-three percent of the uninsured are fully employed. The expansion of private group based coverage could reach a large portion of the uninsured. This mandated approach, with a minimum of regulatory intrusion to implement them would have at least three features: (1) a widely available affordable insurance product; (2) gradual, phased-in mandates; and (3) significant tax relief.

We are, therefore, supportive of Senator Kennedy's minimum health plan in concept, and I have a great deal of your bill, Senate Bill 1265.

Let me state we would have difficulty in this area absorbing any additional burden of uncompensated care by our hospitals. We are, also, supportive of the various catastrophic insurance bills and would encourage the coverage, again, of prescription drugs.

We, also, believe that we need to restructure Medicaid into three distinct programs: (1) acute care coverage for the medically indigent who are not eligible for Medicare; (2) supplementary acute care coverage for Medicare beneficiaries; and (3) long-term care coverage for beneficiaries and recipients.

On a State level, we need to encourage three actions. We need to encourage Blue Cross and Blue Shield of Michigan to increase their participation in offsetting bad debt and charity care and to modify

the payment methodology that payments are more directly legislated at providers having large, uncompensated care burdens.

We need to encourage the State of Michigan to increase the indigent care adjuster, and we also need to require a uniform approach to the resident county hospitalization program.

In conclusion, caring for the medically indigent is a large, growing and increasingly complex problem complicated by lack of consensus on solutions. At issue in the task of insuring health care coverage for the nearly one in six Americans who lack private health insurance, most of the uninsured workers are dependents of those who work, albeit at low income or low middle income levels.

The remainder are unemployed adults and children who do not qualify for Medicare, Medicaid, or non-federal public assistance programs. These groups include the aged, the mentally ill, and the disabled.

Most of the almost 37 million uninsured ultimately receive care, but that care is financed with private subsidies, not through government programs.

In fact, recent trends indicate that hospitals, not government, maintain the social safety net for those not protected by public programs.

We stand willing to work with you and any other legislators to develop a comprehensive solution to this significant and increasingly dramatic problem on the health care of our citizens.

Thank you.

Senator RIEGLE. Thank you, very much.

[The prepared statement of Miss Clevey follows:]

PREPARED STATEMENT OF JUDITH CLEVEY, PRESIDENT, HOSPITAL COUNCIL OF EAST CENTRAL MICHIGAN

My name is Judith Clevey and I am president of the Hospital Council of Central Michigan. The district I represent encompasses fourteen counties, north to Tawas, all of the Thumb, west to Clare, and the tri-cities. I am wearing a second hat as the representative of the Greater Flint Hospital Assembly in the place of David Seaman. The Greater Flint Hospital Assembly represents hospitals in the Genesee, Shiawasee and Lapeer Counties and patients in some three adjacent counties served by these hospitals.

Let me first discuss the cost of care of the uninsured and underinsured to our hospitals in the Flint area and in east central Michigan. Let me then discuss what this actually means to an area like the Saginaw Valley which lost a hospital to bankruptcy in 1986, largely as a result of the significant amount of care provided to those who could not pay. Finally, I will discuss what needs to be done and what could happen to the hospital community and the patients it serves, if nothing is done.

The cost of providing care for those who cannot or will not pay for the twenty-two hospitals in east central Michigan for 1986 was $11 million. Hospitals in the Flint area provided $9 million of free care during this same time period. This financial loss does not represent the truly dire situation hospitals faced during this same period with the decrease in medicare and medicaid funds. Many hospitals in our area were receiving an average eighty cents for every dollar of care given to a medicaid patient. Changes in the way medicare pays hospitals has dramatically hurt the rural and inner-city hospitals.

In a true economic sense, the continued financial drain on hospitals as a result of providing free care and care at less than cost is significant. In the east central Michigan and Flint area, hospitals are the second largest employer. The area is already reeling from the closure of the auto and auto-related plants. We need to protect viable employers such as our hospitals.

We've talked about the economic impact, but the impact on a family that cannot receive health care because of lack of or inadequate insurance is devastating. I know that we will hear later in the hearing about individuals that could not get

care, but let me state that it is unconscionable that we in this country are more concerned with weapons systems that do not work or are over budget than with the health care of our citizens.

Let's now discuss what can happen when the costs of providing care to the medically indigent becomes too much of a burden on one hospital. On October 6, 1986, Saginaw Osteopathic Hospital closed and in so doing left 200 people out of work but perhaps more importantly, left a large segment of the population without access to care. Saginaw Osteopathic Hospital through the years had become the hospital which served a large number of the uninsured. The costs of this care, approximately 15% of their budget, the low payment rates of medicare and medicaid and the high cost of medical malpractice insurance conspired to cause Saginaw Osteopathic to declare bankruptcy. I am pleased that the hospitals in Saginaw have risen to the challenge of serving those persons who had an allegiance to Saginaw Osteopathic Hospital, but the cost of providing additional free care will ultimately severely impact those hospitals as well.

Medical indigence is not a single or simple problem. Finding a solution is not the responsibility of any one group or segment of society. Nor is there "one best way" of addressing the issue. A lasting solution will require efforts by the private sector—by providers, insurers, employers and individuals—and by the public sector—by Federal, State and local government. Above all it will require a commitment by the public to find and put in place the mechanisms needed to address the problem.

The dimensions of the issue can be described by looking at four sets of facts:

The size and characteristics of the uninsured population.—In 1985 approximately 37 million Americans were not covered by public programs. Of these, the majority were employed or were the dependent of someone who was employed. Two-thirds of the uninsured have limited incomes and are unable to purchase private insurance.

The declining adequacy of medicaid.—Ten years ago, medicaid covered nearly two-thirds of those whose income fell below the poverty level. Now, medicaid covers less than 40 percent of the poor. In addition, medicaid has become principally a program of supplemental insurance for medicare beneficiaries, covering those services that are not provided by medicare, e.g., long term and primary care.

Rapid growth in uncompensated and unsponsored care.—Between 1980 and 1984, unsponsored care, care provided to patients unable to pay that must be subsidized by privately insured patients more than doubled. Uncompensated care is rising more rapidly than any source of hospital revenue.

Declining sources of private subsidy.—Between 1980 and 1984, revenue from private sources rose only 40 percent, leading to a situation in which higher unsponsored care costs had to be spread over a smaller base. In addition, competitive pressures reduced the ability of hospitals to shift unsponsored care costs to private insurers.

What should we do about the crisis of care for the medically indigent——

1. Expansion of both private insurance options and public sector programs. It will require the cooperation of government, employers, providing insurers and the uninsured themselves. Because 53% of the uninsured are fully employed, the expansion of private group based coverage could reach a large portion of the uninsured. This mandated approach, with a minimum of regulatory intrusion to implement them would have at least three features: (1) A widely available affordable insurance product; (2) gradual, phased-in mandates; and (3) significant tax relief. We are, therefore, supportive of Senator Kennedy's minimum health plan in concept.

2. A new public insurance program needs to be created for uninsured individuals who cannot be reached via work place accommodations. For the portion of the uninsured population not relaterd to the labor force, a residual or fallback public program could be created. This could be accomplished in one of two ways. The first being funded by state and county government appropriations with revenues from general funding, premiums from beneficiaries able to make a contribution to their health care expenses and provider contributions. Hospital aggregate contributions would equal the current levels of uncompensated care, this representing a maintenance of effort.

The second way would be to restructure medicaid into three distinct programs: (1) acute care coverage for the medically indigent who are not eligible for medicare; (2) supplementary acute care coverage for medicare beneficiaries; and (3) long term care coverage for beneficiaries and recipients.

3. Encouragement of Blue Cross Blue Shield of Michigan to increase their participation in offsetting bad debt and charity care and to modify the payment methodology so that payments are more directly targeted at providers having large uncompensated care burdens.

4. On a State level, the medicaid program currently distributes $30 million by way of an indigent care adjustor which boosts payment rates for a high proportion of medicaid patients, resident county hospitalization [RCH] individuals, crippled children and bad debt cases. The increases and/or revision of the indigent care adjustor should be supported so that it directly targets the uncompensated care burden.

5. Again, on a State level, participation in resident county the otherwise unsponsored population, should be required for all counties according to uniform standards individual counties currently determine eligibility levels and whether they wish to participate in this program or design their own.

CONCLUSION

Caring for the medically indigent is a large, growing and increasingly complex problem complicated by lack of consensus on solutions. At issue is the task of ensuring health care coverage for the nearly one in six Americans who lack private health insurance. Most of the uninsured work or are dependents of those who work, albeit at low income or low middle income levels; the remainder are unemployed adults and children who do not qualify for medicare, medicaid, or nonfederal public assistance programs. These groups include the aged, the mentally ill and the disabled. Most of the almost 37 million uninsured ultimately receive care. But that care is financed with private subsidies, not through government programs. In fact, recent trends indicate that hospitals, not government, maintain the social safety net for those not protected by public programs.

Care for the poo and uninsured is a traditional mission of community hospitals. But an increasingly competitive health care marketplace and the move in 1983 to medicare prospective pricing have limited hospitals ability to shift costs to third-party payers and paying patients to cover indigent care. Those costs are crippling many hospitals and in our area, led to the closure of one hospital.

We stand willing to work with you, Senator Riegle, and our other legislators, to develop a comprehensive solution to the medical indigence problem.

Senator RIEGLE. [Audience applause.]

I think we've had excellent presentations by both our individual witnesses here earlier and by our professionals at this table, and they have put a number of issues out on the table for us to consider.

I have a list here of about thirty or thirty-five people that have asked to speak. We're going to take people in the order in which we have them here. So, rather than go into further questions at this time—because, I think, each of the statements that you have made are quite self-explanatory, and, the comments that have been made along the way have been helpful—we will continue with our audience witnesses with the expectation that comments that will be made will elaborate on things that have been said here.

I want to try to pose another question to the audience as a whole before we finish with this panel. Now that you've heard the professionals speak from various vantage points here, I'm wondering how many of you are of the opinion that this problem has grown to such a dimension that we must do something; where these enormous costs can come down without warning, and, even if you have insurance, you're not sufficiently covered; and the person who doesn't have any at all is totally unprotected.

I'd like to get a showing of the hands as to how many of you feel that the time has come for our Federal Government to take the lead in crafting a broad health protection plan, health insurance, that will not only cover the gaps for the senior citizens, but, also, make sure that there is a health protection plan in place that really gets the job done for families and people of all ages and not just seniors.

How many of you are prepared to see our Government take that step, and, if necessary provide some of the funding for it to see that it gets off the ground and it's done properly? Can I see a show of hands? How many of you would favor that? Hold your hands up for a minute. [Audience complies.]

Very substantial number.

How many, now, would have serious reservations about that and would oppose that? Any hands? [Audience complies.]

I see two back there. I see one here. I see three hands in opposition. So, a very substantial, overwhelming majority feels that way.

Let me, at this point, thank this panel for its testimony. I'm going to now go to the other citizens who have asked to speak, and anybody that's been seated in a chair a long time and is stuck in the middle of an aisle and wants to get up and move around or go to the bathroom or get a drink of water should feel free to do so. Sometimes these meetings take on a kind of formality where you feel like you're stuck in one spot. I don't want anybody to feel that way.

So, I want you to feel like you can move around as you need to because this is a citizen meeting. Although it's an official meeting of the Senate Budget Committee, it's a citizen's meeting. So, you should feel free to move around as need be.

I am going to announce that we have found some keys. Do we know what the keys look like? Here they are. GM keys, four of them on a little round ring. So, you might check and see if you've lost your keys.

Also, those of you that have individual case problems that you need help with and that you want me and my staff to work on for you, we have case workers out in the hallway that are prepared to sit down with you to get the details down in writing so we know precisley what the facts are, and so we know how to follow up.

I'd like to encourage anybody that has a problem like that to let us know.

Now, you and I spoke earlier, and I asked you if you'd be willing to come up and say a few words.

UNIDENTIFIED SPECTATOR. You covered it all.

Senator RIEGLE. But, you said it better than I did when you talked to me earlier. Why don't you come on up just for a minute.

SPECTATOR. I don't feel like it.

Senator RIEGLE. Well, in any event, what you said was——

UNIDENTIFIED SPECTATOR. It's true.

Senator RIEGLE. I know it's true. What you were saying is that the cost of your medicines each month are now to the point where you literally feel you don't think you can make ends meet. Isn't that about the size of it?

SPECTATOR. I don't want everybody to know it.

Senator RIEGLE. Pardon me.

SPECTATOR. I don't want everybody to know it.

Senator RIEGLE. OK. She's feeling a little embarrassed about it. So, she doesn't want everybody to know what her situation is, but she was telling me earlier about what she's facing, and it's only in hearing these individual situations that, I think, we start to really understand what's really going on in our society because most of the people that are suffering, are suffering quietly.

So, they might be down the street or next door, and you wouldn't know they're in desperate need because people are proud, and people don't want to have to tell the world what their problems are. But if we don't know what the problems are, and we don't know how many people have them, we're not going to be in a very good position to figure out an answer to fix it.

So, that's why it's important that everybody come forward. We've got some people here that have asked to speak, and I'm going to start on down through the list.

We're going to stay here and take testimony as long as it takes to get everybody, and I'm going to be here for most of that time. I do have a meeting later in the day that I've got to attend, so we'll start on down through the list. I'm going to ask everybody that comes up to speak to condense their remarks because there is a long list, and we want to get to everybody.

One of the people that has asked to speak is Joan Stull, who indicates that there is a real problem on time. We'll have you speak first. She'll be followed by Ron Warner, to be followed by Peter Levine, to be followed by Bob Braden, and, then, Mr. Phillip Dutcher.

If those five will be ready to go in that order. Miss Stull, why don't you give us your comments, please.

STATEMENT OF JOAN STULL, LEAGUE OF WOMEN VOTERS

Miss STULL. Thank you, very much, Senator Riegle. I'm speaking on behalf of the League of Women Voters in the Flint area. I'm standing in for Jeanette Hall, who isn't ready to speak.

I have written comments, which I shall read.

Our local area of the League of Women Voters has studied health care and health care plus for the past several years. We reached consensus locally on many areas that are relevant to your bill on Senate Bill 177.

I've included a copy of the consensus questions and our local area responses, and that will be in the package given to you. Many millions of persons in this country are uninsured or under-insured.

Our State has thousands upon thousands of such persons. Our local league is delighted to see recognition of this problem at the Federal level. While we agree with the scope of persons to be covered and the sliding fee provisions of your bill, we seriously question the funding mechanism of a 3-percent tax on the gross revenue of most hospitals.

HOSPITALS FEEL GREATER BURDEN

As we see it, the bill places most of the cost of health care for the poor on the hospitals. In the past 2½ years, this State has experienced many hospital closings due to cutback of Medicare, Medicaid funds, and contractual reductions through Blue Cross.

To yet add another burden of tax, especially on those hospitals who are already in serious financial difficulty, may force more hospitals to close. This bill could have especially serious implications for the Northern and Upper Peninsula health care system.

There currently exists an acute shortage of doctors and health care services in that area. We feel that this bill may place an un-

manageable burden on the existing health care system in that area.

Our local league felt that businesses that employ persons at or near a minimum wage, jobs with few if any benefits, had a moral obligation to participate to some degree in the financial obligation of health care for their employees.

Another issue that we had hoped to impress, was that difficult and expensive issue of nursing home costs. Our group questioned the moral dilemma of nursing home costs, and we did not feel that a person should be reduced to poverty simply because they had a family member who became ill and needed long-term nursing care.

Most groups of elderly persons have experienced life-time savings break down within one illness over a very short period of time. Currently, a person must be near poverty before they are eligible for help through Medicaid, at least in our State.

We thank you for the invitation to speak on this issue and hope this bill will be amended in certain areas, sincerely.

Senator RIEGLE. Thank you, very much. I might just say, that in terms of the financing system in my bill, it really gives the option to the State to find an approach because it's the tough part to figuring out how to spread the cost burden, and, so, you savor that latitude to find out that it was other than to lean heavily on the hospitals, and that is a concern of mine.

It's a real problem, as other witnesses have already said today. So, we're open to try to find the best mechanism we can.

Miss STULL. Thank you.

Senator RIEGLE. We thank you for your testimony.

[The consensus questions and answers follow:]

ANNUAL REPORT

The Health Care Cost Containment Committee concluded their second year of study. The focus of this year's study was acces and funding mechanisms.

The committee members attended the series of lectures at the Flint Public Library. Dr. James Flick was the presenter. This series presented the changing health care field and the moral delimas created by the rationing of health care dollars.

Dr. Flick spoke to our committee several months later on dwindling access to health care and the impact that will have on our society; specifically, who will recieve health care in the future and how much.

Shirley Campbell, an R.N. discharge planner for Flint Osteo pathic Hospital, spoke to our group regarding the DRG (Diagnosis Related Grouping). She discussed the impact of Federal Policy on the local discharge planning process for her hospital.

Our League reached consenses on the State Consenses Questions as follows:

A. QUESTION: Is personal health care a right___, privilege___ neither___?
ANSWER : Our League felt that personal health care is a rignt, but not an unlimited right.

B. FUNDING MECHANISMS:

1. QUESTION: Is the present system of funding mechanisms for for health care satisfactory?
ANSWER : We felt that present funding mechanisms for health care are not satisfactory.

2. QUESTION: If your answer to question B-1 is "no", how should it be changed?
ANSWER : Our group felt that some persons are locked out of the health care system, i.e. unemployed person, displaced homemakers, and the working poor, due to lack of adequate funding mechanisms. We also felt that there was inadequate funding mechanisms for respite care for older dependent parents, basic nursing home care, and home health services.

3. QUESTION: How much government regulation of funding mechanisms (all types) should there be?
ANSWER : We think that some regulation of funding mechanisms is necessary, especially in the area of rate regulation.

C. ACCESS--FINANCIAL

1. How much personal health care should people be entitled to? Rate each option 1,2,3 (1 least favored, 3=most favored).
   A. Everyone entitled to all available resources. 1
   B. Catastrophic illness only. 1
   C. As much as a person can afford. 2
   D. Basic health care coverage responding to illness. 2
   E. Basic health care coverage including preventive care. 3

2. How much should government pay for health care for those unable to pay for themselves?
   ANSWER: We agreed that government should pay for health care for those unable to pay for themselves on a sliding fee scale.

3. QUESTION: Should all employers make participation in a financing mechanism available to all their employees?
   ANSWER : Employers should make participation in a financing mechanism available to all their employees.

4. QUESTION: Should employers share the cost of their employee's health care?
   ANSWER : Employers should share the cost of their employee's health care.

5. QUESTION: Who should set the fees for dentist, nurses, physicians, and other health care professionals? Government, Professionals, Marketplace, Professional Orginizations, Other
   ANSWER : The Market Place should set the fees for the various health professionals. The Market Place included all the options that were given.

D. ACCESS--GEOGRAPHICAL

1. QUESTION: Is there a problem with geographical access to health care facilities in Michigan?
   ANSWER : There is a problem with geographical access to health care fscilities in Michigan.

2. QUESTION: If there is a problem, what should be done?
   ANSWER : The Western, Northern and U.P. portions of the State are lacking doctors and the high tech hospitals comparable to the ones found in the highly populated portions of the State. If the State were to offer medical students a partial tuition in exchange for a certain length of medical service in the less populated regions of the State upon completion of their medical education that might be a solution to the doctor shortage in some parts of this State. It was suggested that regional hospitals be established to serve broad areas of the Western, Northern and U.P. These hospitals would be comparable in equipment and technology to those in more urban areas of the State. To offset the distances for families, it was felt that these regional hospitals provide inexpensive accomodations for family members of the hospitalized patient.

E. QUESTION: Should the Certificate of Need process be continued?

ANSWER : We felt that the Certificate of Need process should be continued but that the decision making process should be streamlined. This process, as it currently exists, is so cumbersome and time consuming, that it sometimes forces Michigan residents to go to other states to receive the health care they need i.e. lithrotope machines.

It has been an extremely enlightening study. We feel certain that policies concerning health care costs will have many far reaching implications for health care delivery in this country. We feel that these policies should be closely monitored to insure an adequate level of care and accessibility.

Joan Stull
HEALTH CARE COST
CONTAINMENT COMMITTEE
CO-CHAIRMAN

Flint Area LWV

Senator RIEGLE. Mr. Warner, followed by Mr. Peter Levine.

STATEMENT OF RONALD WARNER, FLINT, MI

Mr. WARNER. Thank you, Senator. I'm pleased to be here this morning. My name is Ronald Warner. I live at 4320 Radcliff in this City. My zip code is 48503.

For the past 30 years, I have given considerable voluntary time to the health care delivery system. My appearance here today is as a concerned citizen, not as an authorized representative of a health care organization, many of which I am involved in serving.

I'm pleased that further national legislative attention is being given to the problems of access, reimbursement, etc., within the care delivery system. My interest in these problems is not new.

As you will recall, we discussed this matter in your office in Washington, DC, when you were a member of the House of Representatives. That means that it was some time ago.

As for legislation that has been focused on the cost of care related to the percentage of the Gross National Product of the Nation rather than the access and quality and fiscal liability of the delivery system.

I wish to emphasize the risk of survival present within the system nationally, and in a 1986 survey by T. Ross, a national accounting firm, indicated that 43 percent of all hospitals within the Nation were considered to be at risk of fiscal failure.

As this effort to provide access to care proceeds, we must share survival of the delivery system that it be there when the people are ready to be cared for and able to finance.

Now, I'm going to respond as you have requested in your letter to the legislation of Senate Bill 177. Now, I am supportive of the idea and the need for revisions and improvements of the system, but I'm going to respond concerning the method that's laid out in your legislation.

As presently drafted, it is very complex and loaded with bureaucratic controls. Now, I realize that you're going to get legislative matters passed at the legislature because it would give a little bit to everybody.

You can't get it through any other way, but I'm approaching this from the standpoint of an idealist. I don't like some of the bureaucratic things that are in it. The fear of a rain on the public treasury approaches an overkill.

It lacks—I think, it lacks equity for the users of the system; this cost shifting that is presently in place is going to be continued, we're going to have to have somebody else to pay for somebody else, somebody else, somebody else.

Rather than unit responsibility, the idea provides a tax on the providers in order to finance this situation. Well, where does the money come from? You're going to tax a hospital, and that money will have to come to the people who are ill and are being cared for by raising the cost their labor conserves.

Now, I think, the service method is a better way of measuring what needs to be done in a system that is loaded with labor intensive activity. Now, I think, that the idea of the providers will increase the cost—that idea will increase the cost of service to

people, and the rates of insurance will go up, and I view this as subterfuge.

Now, if we are going to have the universal health care, and, I think, that's what we're looking at, as a national policy, it makes a national bureaucracy in that if we were to change it, we could avoid fifty additional state bureaucracies by centering this thing Nationally rather than giving every state a chance to set up its own system.

Now, the example I'd like to refer to is with the Social Welfare System. Now, you know that the people who have to have care through the welfare system, it is so complex that even the social workers can't understand it, and when you talk about the worker, and then, you relate that to the user of the services, you can see what this complex situation amounts to.

I think, the ultimate test of such a system is something that the user of the system can understand. Now, when you have that, people will go for it. In any case, I feel that there are systems of universal health care across the world. It's not a new idea. It's working elsewhere, and with our ability to use computers to simulate ideas, I believe, we should take ideas and simulate them, apply it against the population statistics of this Nation and to find the best system, and then, to put it to work.

We won't have to try it out. It will already have been tested. I want to see the evolution of a better system. I'm not against the idea, as I said earlier, I repeat this, I'm not against it. I want it, but I want to see it a workable, equitable system.

Keep it simple. But, before the system took place now is similar to what you're talking about. There are people saying this would be the answer to the hospice. They will make it if they have that everywhere.

Well, there are lots of things wrong with it. If you would examine even the people who, supposedly, benefit from it, they're not satisfied that it is equitable. So, I feel if we can avoid compromise in any of these matters, we can only get better results.

I'd be glad to get into details on it some other time, but time doesn't permit now.

Thank you, very much.

Senator RIEGLE. Thank you. [Audience applause.]

Before you leave, I should—I should acknowledge in the case of Mr. Warner that he is a unique individual.

This is a man who served here in Flint as the General Motors Plant Manager for a number of years in a distinguished way, remained in our community, is here today, has been active in a number of the human service issues in our community, health care being one, with a number of others.

I just want to take my hat off to that kind of commitment to the Flint area, to our community, and to our people on these broad issues.

Thank you, very much. [Audience applause.]

Peter, we're pleased to have you here.

STATEMENT OF PETER LEVINE

Mr. LEVINE. Because of the broad range of comments you've already made this morning, most of which have been medical societies, we will be very brief.

I'd just like to say thank you for allowing us an opportunity to state our opinions on the issue of health care for the uninsured.

The impending General Motors layoffs seem to make this a particularly timely issue, one of which is of great concern, obviously, both to the public sector and/or the health care providers.

We do concur with your earlier comments issue. It very distinctly describes the major problem. The prime thing to remember right now is that there are currently three components to financing health care for the uninsured and the underinsured.

Those are the efforts of physicians, hospitals, and government-based insurance programs. The—I was just recently going through some old minutes of the Genesee County Medical Society that goes back to 1841 and found out that the first meeting of the four physicians who specifically discussed how to arrange for care of people that had nothing to——

Senator RIEGLE. What's the date again?

Mr. LEVINE. 1841.

Senator RIEGLE. 1841, the minutes of the Medical Society here in Genesee County?

Mr. LEVINE. Yeah. The problem hasn't gone away.

Senator RIEGLE. Did you all hear that? That's really a remarkable piece of information. He went back and looked at the notes of the Michigan Medical—or the Genesee County Medical Society in the year 1841.

There were, what? Four doctors, did you say?

Mr. LEVINE. Yes. Yes.

Senator RIEGLE. And, the issue that they were discussing in the notes of that meeting was how to provide care to those people who didn't know how to pay for it. So, that's sort of a striking bit of history here.

Mr. LEVINE. Yes; really, I think, what's at issue here is Congress has to decide whether or not access to health care is a right or privilege, and I know that you're aware of it based on the bill you've introduced, and, I think, that's one way for developing a system, which can, at least, start negotiations on how to do this.

I think, it's going to be a very complex issue that's going to be started. I, also, think that the public feels that right to have a health care access is a right, and, I think, you have to listen to that statement made, and if it's a right, obviously, you have to come up with a way for coverage.

The current programs of caring for the users through the uninsured simply don't cover the cost, and what's happening, is in the private sector is maintaining coverage and care, despite the fact that there is no reimbursement for that because people do need care.

It's really wonderful to be able to speak up here. On June 8, there was a fascinating article on security in Health Care Weekly Review, which is published in Detroit. It discussed the radical de-

crease in obstetricians and gynecologists willing to deliver babies in the Detroit area.

According to this article, many of these physicians are dropping their practices and concentrating totally on gynecology. The reasons for this are twofold.

The first is the cost of indigent care, and the second is the cost of malpractice insurance and liability risks as a result of taking care of the portion of the population which can't pay for the care.

One community has lost 24 obstetricians and gynecologists in the past 2 years. What's happening, really, is that we're—we're finding developments of health care access.

For instance, I don't think that that's actually referring to good care, but I think that it might. I think we can look at other communities and see that these problems are developing.

Hopefully, legislation, which bills are yours, will help alleviate some of those problems. But, if I could just briefly give you a couple of figures which are interesting related to this—I was telling one of our physicians yesterday—I mentioned that this recent obstetrician/gynecologist, his annual malpractice premium is $44,000.

Last year he delivered 135 babies, which means that—given to him at a personal level, if he received, approximately, $600, the cost of malpractice insurance was $326 per baby delivered and represented 54.3 percent of his reimbursement for each baby delivered.

So, we've got two problems to work together from the physician's point of view. It could bottleneck as time goes on if we don't ax this problem, and it also creates some of the, I think, bureaucratical problems that we heard about this morning in terms of the incredible debt load carried by patients, but enough of that.

I think the studies that have recently been done in Genesee County have shown that access does currently exist both in the hospital and in the physician's office for the general population regardless of their ability to pay.

The, I think, the Senate Budget Committee has to start looking at the fact, though, that as a private sector, we can't continue to expand the amount of participation there has in the care of the medically uninsured patient as Judy so beautifully stated.

I think I would like to leave my written comments on the Senate Bills 177 and 1265 as they exist and not go into them here. But, I would like to say that the bill is intriguing and represents a promising start to what I think will be intensive discussions on indigent care.

These discussions are absolutely critical, and I think that the comments of the families here and the providers really reinforce the critical nature of the issue.

Once again, I would like to thank you all for inviting me to be here, and I would like to note that the medical society is anxious to work with you on these issues.

Senator RIEGLE. Thank you very much. I appreciate your testimony, and it's very helpful. [Audience applause.]

[The prepared statement of Mr. Levine follows:]

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TESTIMONY ON HEALTH CARE FOR THE UNINSURED

PRESENTED TO THE UNITED STATES SENATE BUDGET COMMITTEE JUNE 22, 1987

SPOKESPERSON: PETER A. LEVINE, M.P.H., EXECUTIVE DIRECTOR

The Genesee County Medical Society would like to thank Senator Donald Riegle and the Senate Budget Committee for providing this opportunity to present our views on health care for the uninsured. The impending General Motors layoffs in the region, make this a particularly timely issue, and one which is causing grave concerns for both the public and health care providers. There are currently three components to financing health care for the uninsured and under-insured. They are the efforts of physicians and hospitals and the government based insurance programs. Physicians in Genesee County have historically cared for the indigent with no reimbursement or with reimbursement that does not cover the cost of providing care. The Genesee County Medical Society's history of carrying forward indigent care activity goes back to the 1840's. The purpose of this testimony is to explain why we feel, as advocates for the patients served, that Federal support for care of indigent people must be expanded to assure access, not hinderances to its provision services.

It is time for the U. S. Congress to determine whether or not access to health care is a right or a privilege. Most people feel that having access to health care is a right. If health care is a right, it is the obligation of the public to financially support the provision of health care. Currently, indigent care and care provided to the uninsured, is supported in large part by independent physicians, dentists, and community based hospitals. Indigent care which falls under the Mediciad program, often reimburses physicians at less than 50 percent of their costs for providing that care and hospitals at a rate below 100 percent of the costs of providing the care. Consequently, the private sector is forced to accept a lion's share of the responsibility for the uninsured.

As mentioned earlier, physicians have willingly carried forth this duty for years. Is it fair for them to be forced to do so? The health care environment does not permit cost shifting between insurance coverages. There are no liability waivers allowed for the care of patients who are indigent or supported by government sponsored programs. There is no tax write-off for uncompensated or under-compensated care. As a consequence, we are entering an era as a nation, in which a greater share of the burden of care for the poor and a greater liability risk resulting from the care for the poor is borne by physicians. Most physicians are still independent practitioners who are self-employed. As their indigent patient load

increases, along with the liability risk associated with taking care of them, physicians are in increasing numbers being forced to limit or give up care of that population.

On June 8th, Healthcare Weekly Review ran a front page article on the radical decrease in obstetricians and gynecologists willing to deliver babies in the Detroit area. According to this article, many of these physicians are dropping their practices in obstetrics, and concentrating totally on gynecology. The reasons for this are two-fold: first the cost of indigent care; and second is the cost of malpractice insurance and liability risks. On the West Side of the State, one community has lost twenty-four obstetrician-gynecologists, specifically due to the above two mentioned factors. A crisis is developing in access to care. To illustrate the reasons for this developing crisis in access to care, allow me to quote some figures. One respected member of the Genesee County Medical Society is an obstetrician-gynecologist. In 1986, he delivered 135 babies. For each baby, he received $600 in reimbursement. His malpractice premium was $44,000. This translates to $326 in malpractice insurance cost per baby delivered. The cost of malpractice insurance represents, in his case, 54.3 percent of his reimbursement per baby delivered. After seeing numbers like that, it is not hard to understand why physicians are beginning to become extremely upset at the level they must subsidize indigent care, which cannot even cover overhead costs.

As a final comment on general indigent care issues, I believe that it is germane to know that studies performed in Genesee County have shown that access does currently exist for the general population, regardless of their ability to pay. The message that the Senate Budget Committee must comprehend is that there is a limit to how long that can continue. It is time for the Federal government to consider its commitment to indigent care as well as to coverage of the under-insured and to take action to cover it at a level which covers physician costs for providing the care. That is the minimum that the Federal government can do.

The Genesee County Medical Society offices received a copy of Senate Bill 177 on Thursday, June 18th. The American Medical Association has not developed a position on this Bill, but the Genesee County Medical Society would like to comment on it, if it is the pleasure of the committee. It is laudable, that new legislation is being developed to provide a system for caring for the medically indigent and others who provide health care professionals no compensation for care received. We are concerned about the direction of a few components of this Bill. The first concern is that the Bill applies only to reimbursement for hospitals. The second is that it will be heavily funded through taxation of hospitals which are already providing free care in many cases. There is language in Section 3, Item (c)(1)(C), on page 5, which appears to cover some physician services related to emergency, laboratory and diagnostic x-ray procedures. Those three specialties are only a small sub-section of the physician community which provides uncompensated care. In addition, those three specialties have been targeted before under plans for the creation under a pilot Physician DRG system. This component of Senate Bill 177, would appear to allow the hospital to be the primarcy recipient of reimbursement for care of patients, with the payment to physicians being at the discretion of each hospital. The Genesee County Medical Society would be opposed to that.

The Bill is intriguing and represents a promising start to intensive discussions of indigent care, which are of such great importance to today's environment.

Once, again, the Genesee County Medical Society would like to thank Senator Riegle and the Senate Budget Committee for this opportunity to briefly present its views.

PAL/wjf

6/22/87

Mr. Bob Braden, to be followed by Phillip Dutcher, followed by Robert Pestronk, followed by Joyce Johnson, followed by Leroy Nickels. In that order.

Mr. Braden, pleased to have you, and let me hear from you at this time.

STATEMENT OF BOB BRADEN, FLINT, MI

Mr. BRADEN. My name is Bob Braden. I live in Burton, in Flint, with my wife, Jan. I have epilepsy and arthritis. My prescriptions are costing $150 a month. I work as a part-time cashier in a parking lot, an average of 30 to 36 hours per week, at $4 an hour.

In April of 1984, I was laid off from a job I had held for over 4½ years. The company moved the Accounts Payable Department to Detroit, thereby eliminating my job in Flint.

Besides that 4½ years, I have, approximately, 25 years' experience in the wholesale paper business. My specialty has been inventory control stock records.

Since being laid off, I have discovered that it is very difficult for a 56 year old epileptic to find gainful employment. The job interviews get fewer and farther between. While unemployed, I went to computer school and obtained a word processing certificate.

I've had several temporary jobs that lasted only a few months each, but no full-time employment with benefits. I just need something I can use to apply to 30 years experience in skills I've gained.

My income is approximately $502 a month, and $150 must go to pay for prescriptions without which I cannot work or live.

My wife, Jan, has been working as a server at a local restaurant up to a year ago. She had to go on sick leave due to rheumatoid arthritis.

As of this month, she is no longer employed. Although the company does not have long-term disability benefits, they are allowing her to pay $21.64 per month to keep her medical and dental coverage for another 18 months. Jan's physician has prescribed three daily medications for her. Luckily, they are relatively inexpensive.

It is a struggle each month to pay the $21.64 health insurance, although she cannot afford to be without it. This past winter when utility bills were higher, we had difficulty deciding whether to pay them or buy food. There is never a decision concerning my medication. They have to come before anything else.

In 1983, while I was still working, we purchased a used 1980 Oldsmobile Cutlass, which we could afford; that is until I was laid off and lost my medical benefits. My parents paid off the balance of the car so that we would not lose it.

Especially with my present job, we must have a car. I usually get off work between 3 and 4 a.m., as there are no buses running at that hour.

Recently for the second time, we applied for medical assistance through the Department of Social Services. Because we own a car that's valued over $1,500, also, since I choose to work, we are not eligible for GA medical, not even on a spenddown.

Also, I'm not eligible for Medicaid, as I'm over 21 and under 65, and, also I do have a handicap and am not considered disabled.

I am receiving services from the Michigan Department of Rehabilitation. Also, I have applied for employment in the State's Civil Service Commission, where I am considered handicapped by their definition.

Senator Riegle, would you please in your Congress address the needs for affordable medical insurance for families working part of full-time without benefits. I'm certain I am not the only one that has shown here today, paying over a third of their income for prescriptions and insurance.

We are tired of making the difficult choice of which bills to pay or whether we can afford to do the weekly grocery shopping.

Thank you.

Senator RIEGLE. Thank you, very much. [Audience applause.]

Bob, I appreciate your coming and giving that testimony. I know it's not easy to talk about your personal circumstances, but this is the only way we really get the facts on the record and to help convince others in the Senate as to what we're dealing with.

Mr. Phillip Dutcher.

STATEMENT OF PHILLIP DUTCHER, CHIEF EXECUTIVE OFFICER, HURLEY MEDICAL CENTER

Mr. DUTCHER. Thank you, Senator Riegle.

I'm Phillip Dutcher, the Chief Executive Officer of Hurley Medical Center in Flint. I'm here today to address the issue of health care for the uninsured, and to comment on your proposed Senate Bill 177.

I think you have heard some very remarkable testimony this morning, from both those who receive care and those who provide it. It's important that you understand the significance of this problem here in your own hometown.

I'll begin my remarks by identifying the situation of uncompensated care at Hurley Medical Center.

Starting from 1983 to 1986, the dollar amount of uncompensated care at Hurley has increased by over 100 percent, from just under $3 million in 1983 to over $6 million in 1986. You heard earlier testimony that the total hospitals in the Flint area have contributed about nine—Hurley Medical Center contributes about two thirds of uncompensated care in this community.

This represents a rate of increase of over a million dollars per year in increase of uncompensated care delivered to the population of our community.

From projections of 1987, this trend does not seem to be changing.

Senator RIEGLE. Let me just stop you at that point and ask you a question, not to throw you off your testimony, but others representing other hospital facilities mentioned this enormous increase in unpaid bills. The carrier giving to the people who can't afford to pay, and there is no insurance.

How, in effect, do you pay those bills? In other words, where does the money come from, that covers the cost of care that you give to people when they're not able to pay for it.

Mr. DUTCHER. Over the years the medical reimbursement—health care reimbursement allowed for a situation such as hot

shipping. Those who have the ability to pay end up subsidizing those who are not able to pay.

For the most part, that's how uncompensated care in health care, at least in the hospitals, is paid for.

Senator RIEGLE. Now, if I can just ask you one other question. That scheme of taking the hospital population of those that can pay and of those that can't, in fact, the grades for those that can pay get adjusted upward to provide the extra money to pay for those who come in and need the hospital services and can't pay.

Now, you could say, if you're going to put that cost on somebody, rather than putting it on the population based on people who use the hospital, which by definition those people who are sick, if you were to go to a broader base, if you were to go the base, say of everybody who has health insurance now, who has private health insurance, that would be a broader population base. You would have the people that get sick and need the care, and then you'd have all the rest who don't get sick and don't need the care and so you'd have a much broader population base, and you'd have a different kind of cross profile. If you had to apply the cost of the bills for those that need help and can't pay for it cross that much broader insurance population base, it seems to me that that would be—I'm not proposing that—but that would be an alternative.

Obviously, the alternative in the broadest example would be what Mr. Hughes and others have talked about—going to an actual national health system in the country where you apply it across the whole base of the population.

You do it with some kind of a governmental involvement in formulation, but you'd actually pick up two hundred and forty million Americans, and you'd put everybody in the base, and you'd spread the cost to those who need help and can't afford it across that, you know, the entire life and breath of the population.

So, if we think about how to apply these special costs that we now don't have a way to pay for, I think we have to be open to various ways in which to define the population over which those costs are carried.

I'd like you to know, I'm very much open to that question of how we look at those alternatives and find the best one because I don't think we, at the moment, know the precise answer to that question.

I agree with your analysis. That that would be a much better, much greater mechanism to allocate the cost of health care.

Mr. DUTCHER. The population of patients that receive this uncompensated care, as you have identified in your bill, is a mixture of uninsured and employed, uninsured and recently unemployed, and the traditional indigent population.

The situation is of major significance to the Flint community as the population of unemployment grows.

The ability of institutions like Hurley, to continue to provide not only the services most needed by this Michigan population, those being preventative care and health maintenance, but, also, the basic health care services such as emergency room and urgent ambulatory services is threatened.

We have already seen examples of these services being stopped by hospitals in the Detroit area due to the financial instability they

cause. The problems of the inability to cause shift reductions in Federal—in funding of Federal and State health care programs, the competitive environment fostered by HMO's and PPO's and the severity of illness of those patients committed to hospitals today are placing increasingly intolerable financial demands, especially upon Urban public hospitals.

Hurley's situation is compounded by the fact that there are significant teaching programs in place that not only serve as a manpower resource for our communities health professionals but, also, as a relatively cost effective mechanism for providing health care to the indigent population.

Without the medical education programs at Hurley, the cost of providing an equivalent level of health care to this population would be greatly increased.

The concern that should run through all of our minds is that at Hurley Medical Center, or an institution similar to it, they are unable to fulfill its mission of care regardless of ability to pay. Who will provide that safety net?

Senator Riegle's proposed bill, the health care for the uninsured is not necessarily the final solution to this national problem, but it is a giant step in the right direction. The proposed bill is very similar to one recently enacted at the State level in Florida, known as the Public Medical Assistance Trust Fund.

This program has been identified by the National Association of Public Hospitals as quote, "a significant improvement in the availability in financing of health care for low-income uninsured patients in Florida." The new measure will, also, expand Medicaid eligibility and create new programs for obstetrical care, neo-natal care, dental services, home health primary care and childhood and adult medical screening.

Senate Bill 177 has a bureaucratic structure to it, albeit State funds and Federal. It takes from those institutions that profit and gives to those that provide significant uncompensated care.

It limits the taxing power in hospitals, and not the other area of health care providers. However, without a program in place such as the one proposed here, the safety net for the uninsured will not exist.

Without a program in place, hospitals such as Hurley Medical Center and many others like it will be forced to make resource allocation decision contrary to the well-being of this growing segment of our community population.

Thank you, very much, sir.

Senator RIEGLE. Thank you. Before you leave the microphone, let me ask questions and make a point.

I think the plant closings that we're facing in our community make this a more urgent problem for us to face and to be prepared to deal with because we are going to have more and more people out there who are not going to have health care coverage, and they're going to be in our community, and we're going to have to find a way to meet their health needs.

Can you tell me roughly what the cost rate per day is today at Hurley Hospital, just some rough numbers?

Mr. DUTCHER. The rough cost of one day stay at Hurley Medical Center is probably about $750.

Senator RIEGLE. The cost is $750 a day. Can you give me an idea how much of the $750 a day cost represents the unpaid for bills that you're having to pick up, in a sense, by increasing your daily rates for those that can pay to pay for the service that you give others that where you aren't able to collect or not able to pay?

Mr. DUTCHER. Hurley Medical Center's uncompensated care is about 6 percent. So probably it's in the area of $45.

Senator RIEGLE. $45 of that $750 a day would represent somebody else's bill that they've incurred but couldn't pay, and this is one of the ways in which you pick up the money you need to pay for those services.

I appreciate your testimony, and it's very helpful to us. Thank you.

We'll have next Mr. Robert Pestrok, followed by Joyce Johnson followed by Leroy Nichles followed by Bonnie Leterneo.

Now, I know some people are having to leave because they have other things to do, and if you're not able to stay until your name is called, if you've got comments that you could leave with our staff people outside, or if you can write a statement out and leave it. Otherwise we'll just continue on through until everybody who's asked to speak has a chance to speak.

So, Mr. Pestronk, may we please hear from you now.

STATEMENT OF ROBERT PESTRONK, DIRECTOR, GENESEE COUNTY HEALTH DEPARTMENT

Mr. PESTRONK. Senator, thank you for the opportunity to testify. I'm providing a copy of my prior statement to your office.

My name is Bobby Pestronk. I am the Director of the Genesse County Health Department. I'm here today representing a county agency by State code, for the protection and promotion of public health.

This is becoming an increasingly difficult job to do. Specifically, the local health department endeavors to prevent disease, prolong life, and promote the public health, and to organize programs in personal and environmental health.

Health problems which are particularly vulnerable populations are specific focuses of the department. Citizens who have health insurance without adequate coverage represent the vulnerable population.

Whose good health insurance in Genesee County, users of health care, providers of health care and the community as a whole. Citizens in Genesee County are without adequate coverage for health care.

A recent survey in Genesee County estimates the number of citizens without any type of coverage is approximately twenty-two thousand. Some citizens, despite adequate resources, choose to be without coverage. Many other citizens have no choice.

Individuals are without coverage for a number of reasons. The typical of those without coverage are those without income, or with little income, dependents and female-headed households.

There is a system of care available to the uninsured, underinsured and unemployed. It involves the public, private and volunteer organizations of this community.

In addition, the Genesee County Public Health Program such as the supplemental food program for women, infants and children, the WIC Program, the State and Federally funded family programs for the childrens service's, early and periodic screening diagnosis and treatment. Primary care services delivered by the Genesee County Health Department are available.

Recent discussions within Genesee County by a committee called the Committee Concerned with Health, on part of many providers of health care indicate that this system is currently strained under its current load of service and additional resources, such as the billing.

The present system is complex and uncoordinated, and this type of insurance access is difficult for citizens to use, and understandably so. Mr. Levine has spoken about uninsurance toward providers of health care, as Mr. Dutcher has specifically, so, I won't make my comments on that.

Society, itself, is uninsured against preventable disease. Public policy must encourage citizens to take steps to protect their own, their families and their neighbor's health.

We see the extent to which communities are currently underinsured.

As we examine, for example, the rates at which AIDS and other sexually transmitted diseases are prevalent in our community. We observe the extent to which communities are underinsured as we examine the inconsistent and conflicting messages which citizens receive about livestock. Some messages encouraging the neighbor which increase practice of hazardous behavior, while other messages warn against the same behavior.

Attentions and messages concerned with proper nutrition, exercise, stress reduction, moderation and alcohol and tobacco use, will help ensure society against unnecessary disease.

According to a recent report, only 13 percent of Michigan citizens eat balanced meals each day. Fifty-five percent are overweight. Only 28 percent maintain a regular exercise program. Over 30 percent of Michigan adults are smokers, and 35 percent report drinking heavily one or more times per month.

We can provide insurance by recognizing the value of accurate and consistent information, by ensuring that the will and resources are present to support the educational and public information that were necessary to convince citizens of the importance of prevention.

In part, the conditions I've described demonstrate that health care cannot be left to the invisible family in the marketplace. Government must take an active role to ensure the citizens that the services which have become an integral part in daily lives of citizens, whether they are providers or users of service, continue to be made available to those who cannot afford or are not in a position which allows them to have access to insurance.

What can we say about ourselves when we cannot provide all of our citizens access to health care, and access to information and education by which we can maintain ourselves?

We can't afford to pay to maintain our present system. We cannot afford not to pay and not to take steps to advance our system, particularly in the areas of preventive health care.

Most of the insurance packages look like the program should be based on the following principles: All citizens should have access to adequate nutrition, preventative care, hospitalization, mental health services, medical care, hearing and vision services, dental services, nursing home and home health services, prescription drugs.

The program should be financed by contributions from citizens, government and businesses. Working citizens should have contributions planned over a lifetime where the contribution is figured progressively based on income.

Programs should be administered Nationally to ensure that services are uniform throughout the country. Steps being taken now in the Federal legislature to address catastrophic health coverage will help fill some gaps, the more comprehensive package service that needs to be made available to all citizens.

Genesee County has been selected recently as the Urban test site for the health care access project. The selection of Genesee County in part reflects the broad and extensive community interest here in addressing uninsurance and underinsurance.

The program will combine State, Federal and local government funds to those from participating employers, employees and private foundations to provide affordable coverage to some low-income workers whose employers agree to participate, thereby filling a current gap in health care coverage.

It will, in addition, test the power of health insurance to keep people working and off of more direct forms of public assistance. Statistics in the State of Michigan indicate that one of the major reasons citizens leave public assistance for work and return to public assistance, is the sudden onset of illness in the family. This illness requires the citizen to return to public assistance to receive Medicaid benefits.

And herein lies the connection with unemployment. The availability of low cost health care insurance may help citizens maintain self-sufficiency and their dignity as working participants of society. The availability of jobs and the income derived from those jobs, help ensure citizens' ability to be counted among those adequate levels of insurance.

Full employment, as well as universal coverage, are objectives to be addressed by National policies.

Thank you, very much.

Senator RIEGLE. Thank you, very much. I appreciate your comments. [Audience applause.]

Mr. Ron Watson has been here for some period of time and will have to leave shortly, and has asked to speak, and I'd like to ask him now to come up at this time and—Mr. Watson, I don't know whether you prefer to speak—to stand up to the mike or if you prefer to take a seat at the table.

STATEMENT OF RON WATSON

Mr. WATSON. Senator Riegle, I just wanted you to know about the hardship that I have. I lost my left leg and hip——

UNIDENTIFIED SPECTATOR. In the mike, please. In the mike.

Senator RIEGLE. We'll push it down for you.

Mr. WATSON. OK. I just wanted you to know about the hardship that I have had since I lost my left leg and hip in 1961, when I was 14 years old.

At that time, we didn't have any big settlements or anything. I had the $25,000 judgment, and I didn't get anything out of it. And so, I kind of had to face a lot of things by myself.

I do have Medicare Health Plus, and it has helped alot. But having my left leg off so high, I have a problem too. So, I'm paying out anywhere from $90 to $100 a month for my equipment.

My medication is over $100 a month, and I only receive $490 Social Security. That's all the money I get. That's it.

My mother, she's been quite ill, and the doctors told her that she ought to go South for the winter. So, I called my Medicare Health Plus and told them that I would be out of State for 4 or 5 months.

Well, they informed me that if I was out of State for over 3 months, my insurance was no good. So, I had to cut it short.

So, I'm having an awful time with trying to keep my head above water. My mother and I live together and there's no way I could make it with $490 all by myself.

And I just wanted to have a chance to tell you this.

Senator RIEGLE. Well, I want to thank you for coming, and I appreciate the fact that you did and that you waited to have the chance to speak.

Mr. WATSON. OK, thank you. [Audience applause.]

Senator RIEGLE. You know, there are so many stories like this, and they tend not to be told unless there's an opportunity for this information to be collected in an organized way. So, I really appreciate all the citizens that come to provide the kind of evidence and testimony that we just happen to have here.

So, we particularly thank Ron Watson for coming.

Joyce Johnson is next. We'd be pleased to hear from you now. Leroy Nickels will be following you. Bonnie Latorneal, and I know some people have turned in their testimony, followed by Charles Wilson then Lizzie Love and Phil Kell, and, then, I believe, it's Archie Johnson.

Joyce, we're pleased to have you.

STATEMENT OF JOYCE JOHNSON, DIRECTOR, VETERAN'S INFORMATION SERVICES, GENESEE COUNTY

Mrs. JOHNSON. Thank you, it's a pleasure to be here. I'm the Director of the Veteran's Information Services for the county. And, to begin with before I state my case, I'd like to say that at the present time, 30 percent of my income goes for taxes. And that's on one hand; but on the other hand, I'm a firm believer that I'm my brother's keeper, and rather than have him hold out, they can take another percent of my money for the program.

The case that I have that I'd like to discuss with you is a widow, she is 77 years old. Her medical expenses for a year are $20,759.32. That may be a little bit more or a little bit less. Her income is $6,006.

Now, her balance is $14,699 for the past few years has been picked up by a trust fund.

We're not set up for an ongoing situation. In fact, if somebody looked at the record, they'd probably say, "What are you doing this for, because this is against the rules?"

This lady is housebound, and part of her medical problem is that she needs distilled water and bandages. Her bandages for one month are $281.04. That's a lot of money, and her drugs are $170.33.

So, when you put together this new bill of yours, try to include things like distilled water, and bandages. Not just pills and hospitals, and—she's bad enough off that the doctor makes housecalls. How many doctors do you know today that make housecalls?

She cannot leave—she lives on Court Street in those little apartments that look like hotels because of the ulcers on her legs. She cannot have stairs or anything like that. We have investigated Social Services and investigated everything to kind of help us a litt'e bit, so that this woman would not be neglected.

Thank you.

Senator RIEGLE. Thank you, so much, for coming and telling that story and, also, for your own personal leadership involvement. [Audience applause.]

It's so wonderful to hear somebody say that even though they're paying a lot in taxes, if they had to pay a little bit more so that everybody would be able to live decently, they'd be willing to do so; and that says something about you, and we appreciate your testimony very much today.

Mr. Nichols. I saw Leroy here earlier, and I think he probably had to leave. So, I assume he's left his statement behind.

Bonnie Laterneal. Am I pronouncing it right. Is she still here, from Davison? I assume she had to go, as well.

Charles Williams. I saw Charles here earlier. I gather he had to leave.

Lizzie Love. To be followed by Phillip Kell, and then Archie Johnson, and Judy Dejong.

Lizzie, it's nice to have you today. Can you pull that microphone up just a little bit so—it just pops on there. You can just pop it on there. That's right.

STATEMENT OF LIZZIE LOVE

Mrs. LOVE. Senator Riegle and platform guests and members of the audience, when I came today I was wondering if anything in the health care program would be addressed to the unemployed. Those that are getting to be of the unemployed and—but I didn't prepare any statement.

I know a lot of general people that are out there unemployed now, that are out of their monies for doctor bills and hospital bills. Just the little bitty necessities like a tooth extraction or a pair of eyeglasses, and I'm really thankful to see that in you bill there is some thought about the unemployed.

I'm almost to that position. I'm back to work now, but how long I'm back to work, I don't know. I work through a committee that's called Jobs and Justice Fight Back, and our purpose for this is to fight for our jobs. If we have our jobs, we can pay our medical bills.

And thank you for considering us.

Senator RIEGLE. Thank you, Lizzie for coming here. Thank you so much. [Audience applause.]

Mr. Phillip Kell. Mr. Archie Johnson from HillCrest in Flint, is he here? Judy Dejong, spelled D-e-j-o-n-g. Rabbi Shuster, Rabbi Shuster here?

Beverly Roman. Lou Panten. Lou Panten from Hamilton Avenue. Brad Hisieu? Helen Hoyt.

Helen we're pleased to have you. To be followed, if he's here, by John Nearhouser. And then Vern Smith and then Shaney, and then Gary Hankinson.

So Helen, pleased to hear from you now. Thank you for your patience and waiting this morning.

STATEMENT OF HELEN HOYT, PRESIDENT, LEAGUE OF WOMEN VOTERS, FLINT, MI

Miss HOYT. I'm speaking as President of the League of Women Voters of the Flint area, and our health care director spoke earlier and we are kind of dividing up the task. We didn't have a State position which resulted from our health care study. I think, perhaps, the thing might be of value to hear what the consensus was of the League of Women Voters Locals in Michigan.

The League of Women Voters in Michigan supports equal access for all to quality health care at a reasonable cost. Cost effective methods of health care delivery which do not sacrifice adequate care for the individuals.

Fees for health care professionals that reflect a combination of Government, marketplace and provider considerations. Those are just the general overall broad statements which are further divided into more specific things, such as facilities.

Under facilities there is certificates of need and discretionary bed use programs are recognized as important methods of encouraging efficient operation.

The certificate of need process should continue and include the following points: Periodic review of the dollar threshold. To streamlining the process and strengthening it to stricter enforcement.

Three, limiting the process to new or additional medical treatment facilities and equipment. A second main point is to ensure that the most cost effective and least restrictive health care systems are utilized.

A full range of medical options should be available, including hospitals, nursing homes, home care, minor emergency centers, ambulatory care, out-patient surgery, adult day care, hospice program, and so forth.

I notice that your bill did not include convalescent care, which would be a large lack. Are those, perhaps, covered under the catastrophic?

Senator RIEGLE. No; they're not. That's one of the gaps in nursing home care, if you're thinking of nursing home care being convalescent care.

Miss HOYT. Yes.

Senator RIEGLE. No; that's an area now that is not presently covered under Medicare. You do have coverage if you exhaust all your

resources and your assets, and you go on Medicaid, and, then, you're eligible.

That, for the overwhelming portion of the people who are not in that welfare status, there is no coverage, and the totals now that the President has made, and they are working their way through Congress, also, do not cover long-term nursing home care.

What we provide in the legislation is a huge need; a gigantic need. So, what we do is we provide for a full blown comprehensive study of that problem to try to figure out how we, then, move on to the next step to address that issue.

So, we're talking there about a figure, I think it was $37—$37 billion item, and that's just sort of the tip of the iceberg because there is an awful lot of people getting home health care where members of their family might otherwise be in nursing homes that are not there, in some cases because there isn't the money to pay for it.

So, sometimes people get home health care for reasons that their families prefer to have them there. But, in any case, it's a cost issue, so, this figure is probably a lot bigger than $37 billion.

So, in order to try to figure out how to provide that kind of coverage is an issue that the country hasn't yet gotten to, but we need to.

The average person that stays in the nursing home; last year the figure was $22 thousand a year. Now, there aren't too many people who are able to spend $22 thousand a year for very long on nursing home care without, you know, exhausting their natural base.

So, that's where that stands at the moment.

Miss HOYT. I was very encouraged earlier when you were giving statements about Star Wars. I think, that about 10 percent of the Star Wars program would cover that.

The league has a very strong position against the Star Wars program.

Senator RIEGLE. Good for the League.

Miss HOYT. Medical personnel. This is kind of all comprehension. There are two points: Use of alternative providers, such as specialists and therapists should be encouraged when appropriate.

Point two, providers encouraged to share the responsibilities of controlling health care costs. The risk/benefit relations should be considered when prescribing testing or treatment with a patient involved in making decisions.

The next point is consumers. It has, it's more or less—I'm going to cover it and be a little more brief. They have; consumers have a responsibility to eliminate use or services and, also, to watch their health habits. Professional liability is that professionals should provide competent care, and consumers have an obligation to act responsibly in considering malpractice a professional liability suit.

Third party reimbursement. Here, it just suggests that pre-paid plans, such as health maintenance organization, per provider organizations should be included as alternatives to other type funding plans.

This point is important, I think. In order to avoid the need for acute care, reimbursement should be available for health promotion and health maintenance services. As we see that in your bill,

there was routine or general health care to avoid an acute condition.

Direct reimbursement should be made available for qualified alternative facilities and for personnel. The final one—point—has to do with access. There are two points. (A) to eliminate financial barriers which may prevent participation in any health care funding mechanism. And, under that, there are two points.

Public funding should be available to those unable to afford the cost of health care or participation in any health care funding mechanism, and this is one part which is not included in your Bill, as far as the funding is concerned, which is two, employers should make participation in funding mechanism available to their employees and should share the cost of health care with their employees.

Major point two, adequate medical care facilities and services should be provided and geographical areas defined is undeserved.

This study was undertaken over several years. It was completed. This is our new position from which we can advocate. I'm hoping that you will take a look at it and generally include it for recommendations in your legislation, especially to convalescent care, prescription drugs, and so on.

Senator RIEGLE. Thank you, very much. I appreciate all the work that has been done to develop this recommendation and to give those considerable care and attention.

Mr. Vern Smith, followed by—let me just see who is here so that we can know who's in line. I want to try to pronounce this right—Shanthy Sewanja, is that person still here? Is Gary Hankinson still here? Is Elmer Neman still here? Susan Laphin, Laphin, L-a-p-h-i-n?

Joan Pheney, Joan is—you'll be next Joan. Brian Stork?

Mr. STORK. Here.

Senator RIEGLE. You'll follow Joan.

Kenneth Gunnels, Ken you'll be next.

Gail Potter, she's still here.

Vern Reckless? Shirley Robinson? Jesse Smith, Fredric Martin Haley? Ann Harris? Charlene Hopkins?

OK, we'll move on from there.

We'd be pleased to hear from you now.

STATEMENT OF VERN SMITH, POLICY DIRECTOR, MICHIGAN MEDICAID PROGRAM

Mr. SMITH. My name is Vern Smith, I'm the Policy Director for the Michigan Medicaid Program. I'm here today representing the Michigan Department of Social Services which I'm assigned to work in the Medicaid program.

For the poor who face health problems to an even greater extent than the non-poor, the importance of health insurance would seem self-evident.

The importance is underscored by a recent Department of Social Services study which was done to look at the relationship between health insurance and employment. My remarks today are going to focus a good deal on the relationship between health insurance and employment.

What the study found was that when welfare recipients take jobs and leave welfare, about half of those persons take jobs in which there is health insurance, and about half take jobs in which there is not.

When we go back in the Department of Social Services and look to see which of those people who are not able to keep their job who left or quit their jobs, for one reason or another, we find that 8 percent of those who come back on welfare, were in jobs that did not have health insurance.

Senator RIEGLE. A very important statistic.

Mr. SMITH. One approach to addressing this issue is a special project known as Health Care Access Project. The purpose of this project is to provide health insurance for a certain segment of the uninsured. Those who have taken a job to get off of welfare. Under Johnson Foundation's Health care for the uninsured program, the Michigan Labor of Human Services and the Michigan Department of Social Services are jointly carrying on a demonstration project at an urban site and at a rural site, for the next few years in Michigan.

The urban site is right here in Genesee County, while the rural sites are in Marquette and Delta counties in the upper peninsula. In selecting Genesee County, the selection committee was impressed not only with the severity of the problem, lack of health insurance in this county but, also, with the extraordinary level of community support and cooperation in addressing the issue of health care for the uninsured.

Along with hospitals and physicians, the local health department and Social Services Departments, community organizations and Charles Stewart Mott Foundation, local officials and State level officials, representing Genesee County all pulled together with impressive results and commitment of resources to address this significant issue.

Over the next few years, we're looking forward to working with the local health officer who spoke earlier about this project. Charles Williams medical and employer communities to see if we can't find an avenue to provide and improve health insurance coverage for these persons.

The project targets efforts of about 10,000 Genesee County General Assistance recipients with special focus on those 1,500 who—to take a job.

To carry out this project, we're going to be answering some important questions which are important to this issue before you and Congress today. For example, will those employed pay up to one third of the cost to participate in such a plan, perhaps $20 to $25 per month per person?

Will employers who hire welfare recipients who have not provided health insurance before buy into a subsidized plan? Will providers be willing to participate? Will the rates be actually sound, and so on?

The challenge, then, is to try to find the health benefit coverage which will facilitate a successful transition from public assistance to work. To be successful the health benefit has to be one which will avoid lost coverage when using ADC or welfare in going to work.

Will the plan contribute to lasting self-support, and not a return to welfare assistance? Skipping over a number of the specific recommendations which are in the written testimony, but the bottom line is that the recommendations which we would make, is that through changes in the Medicaid statute, this State be provided with sufficient latitude so the State policy makers can use their own ingenuity to craft solutions and programs uniquely appropriate to each State's own situation so that welfare recipients can move from assistance into the employment arena.

Probably, the strongest recommendation we would make today, would be a recommendation along the lines of Senator Kennedy's bill, in terms of universal minimum work related health coverage. If we have universal minimum coverage, then we could be talking today about cost of living.

Temporary subsidy employers who hire welfare recipients there would be willing to drop or cliff for recipients to fall off in terms of their health insurance coverage.

When they leave welfare, instead we're dealing today with issues of fairness and equity as some employers give benefits and some don't. Some employers choose to provide health insurance and some don't.

Be glad to work with you in answering questions if you——

Senator RIEGLE. Thank you. I'm not going to ask any questions now, but you've raised a key issue, and it's one in which I'm involved in discussions right now with Senator Moynihan, who is developing a welfare reform bill. We're going to be very interested to see the results of the study that's being done here.

Mr. SMITH. I'd be happy to work with you.

Senator RIEGLE. Thank you.

[The prepared statement of Mr. Smith follows:]

U.S. SENATOR DONALD RIEGLE'S

PUBLIC HEARING

on

HEALTH CARE FOR THE UNINSURED

Statement of

Vernon K. Smith, Ph.D.
Director, Bureau of Program Policy
Medical Services Administration
Michigan Department of Social Services
Lansing, Michigan 48909

June 22, 1987

Statement of
Vernon K. Smith, Ph.D.
before
U.S. Senator Donald Riegle's
Public Hearing on
"Health Care for the Uninsured"
Flint, Michigan
June 22, 1987

I. Introductory Statement

Senator Riegle:

My name is Vernon K. Smith. I am the Director of the Bureau of Program Policy for the Medical Services Administration (the Medicaid Program), Michigan Department of Social Services. Formerly, I was budget director for the Michigan Department of Social Services.

I also currently serve as director of the "Health Care Access Project," a new demonstration project partially funded by the Robert Wood Johnson Foundation's Health Care for the Uninsured Program.

I am here today as an analyst, representing the Michigan Department of Social Services, to discuss issues which arise in trying to strengthen the effectiveness of welfare-related work programs through a modified Medicaid health benefit which would extend beyond the end of eligibility for welfare cash assistance.

II. The Value of Health Coverage to Employment

For the poor, who face health problems to a greater extent than the non-poor[1], the importance of health insurance coverage to employment would seem self-evident.

The importance of health coverage is underscored by the results of a recent study conducted by the Bureau of Employment Services of the Michigan Department of Social Services[2]. This study found that persons who

left AFDC because they were employed were about as likely to have taken a job in which there was employment-related health insurance (54%) as to have taken a job without health insurance (46%). However, of those who lost or left the job which got them off of public assistance, over 80% were in jobs with no health insurance.

Other factors, such as the type of job or the rate of pay may have been factors in the loss of these jobs. Clearly, however, there is a strong and significant association between the lack of health insurance and the loss of employment, among AFDC recipients.

The study concludes: ". . . over half of all responses by the employed (subsamples) cite the lack of health insurance as a major problem, followed by difficulties with transportation and child day care. For those respondents who had become unemployed, lack of health insurance and transportation problems account for about two-thirds of all comments."

III. Michigan Health Care Access Project

Under the auspices of the Robert Wood Johnson Foundation's Health Care for the Uninsured Program, the Michigan League for Human Services and the Michigan Department of Social Services are jointly carrying out a demonstration project in an urban and a rural site over the next two years.

The urban site is here in Genesee County, while the rural sites are in Marquette and Delta Counties in the Upper Peninsula. In selecting Genesee County, the selection committee was impressed with the extraordinary level of community support and cooperation in addressing the issue of health care for the uninsured. Local hospitals and physicians, the local health department and social services department, community organizations and the Charles Stewart Mott Foundation, local officials and state-level officials representing Genesee County, all pulled together with impressive resolve and commitment of resources to address this significant issue.

We look forward to working with this community over the next two years in addressing health care issues for a significant segment of Genesee County's uninsured through this project.

The project will target its efforts at 10,000 Genesee County General Assistance recipients, with special focus on the 1,500 who leave welfare each year with a job.

A key feature of this project is the "One-Third Share Plan." The "One-Third Share Plan" is designed to provide an affordable health benefit to persons who leave General Assistance or AFDC due to employment, whose jobs provide no health insurance and any other coverage (such as a Medicaid extension) is exhausted. Under this plan, the cost of care, in some kind of a managed care system, is to be shared equally in one-third shares by the employee, the employer and the state.

In other words, it is a subsidized health insurance plan which will be made available to persons who work their way off of welfare, and to the employers who hire them.

In carrying out this project, we will be answering some important questions which are important to the issues before the Congress today. For example:

- will low wage employees pay one-third the cost -- perhaps $20 per month per person -- to participate in such a plan?
- will employers who hire welfare recipients, who have not provided health insurance before, buy into this subsidized plan?
- will case management providers, such as HMOs, be willing to participate in this plan?
- will the rates be actuarily sound?
- will a modified coverage provide adequate care?
- will the copayments, deductibles and benefit limits lead to an affordable program?

IV. The Problem With Current Policy

The problem with current policy is that the Medicaid health benefit coverage is tied directly to eligibility for AFDC or SSI. In general, when a recipient of public assistance gets a job or leaves the welfare roles, all too often -- over half the time in Michigan -- the success of employment and independence from welfare is countered by the precipitous loss of the Medicaid, with no other health benefit coverage to replace it.

This is the so-called "cliff" problem, or the "notch effect."

There are Medicaid extensions now in place for up to 15 months. These Medicaid extensions are supposed to be automatic, based on earnings, hours worked, or end of eligibility for the "$30 and 1/3" earned income disregard. In practice, at least in Michigan, the extensions seem to be seldom used. Recipients seem not to request this benefit, and workers, who have enough to do already, seem not to mention or initiate it. Michigan currently averages 3,500 cases per month in the special Medicaid extension categories, while almost over 20,000 cases per year are coded as closed to employment and would presumably be eligible for the extended coverage.

V. The Challenge: Transition Health Coverage

The challenge and the objective then is to design a health benefit coverage which will facilitate a successful transition from public assistance to work.

To be successful, this health benefit should be one which:

- avoids the "cliff" of precipitous loss of coverage when leaving AFDC due to employment
- will contribute to lasting self-support, not a return to welfare assistance
- will be used by eligible recipients
- will be affordable -- to states, to federal government, to employees who were on welfare

VI. Medicaid Authority Required to Provide Transition Health Coverage

Health benefit coverage which would provide the best transition to work would, for most states, be different from traditional Medicaid coverage.

The target population for this transition coverage is limited to persons who are earning enough that they are above welfare benefit levels -- although not necessarily above poverty levels.

Therefore, the benefit package can be designed to "step down" the cliff, rather than simply postpone the fall to a future date at the end of a Medicaid extension.

To do this will require new authority under Title XIX of the Social Security Act. This authority should replace the existing Medicaid extensions with provisions which provide the latitude for states to adopt the following:

- Amount, duration and scope of benefits: Benefits should be different from traditional Medicaid, and more likely mainstream work-related insurance. For example, coverage might not include skilled or intermediate nursing home care, or might include specific limits on inpatient hospital care. Coverage for full primary care and pregnancy-related care, however, should be no less than Medicaid.

- Copayments and deductibles: Employee cost-sharing should be similar to work-related insurance, which would exceed current Medicaid limits. For example, nominal copays on physician, emergency room and outpatient hospital visits and prescribed drugs might be elected by a state to help make the extension more affordable. A coinsurance of $100 for an episode of inpatient hospital care would be considered reasonable in some states, and would not unduly compromise the general need for first dollar coverage for persons eligible for this kind of plan.

- Eligibility limited by total income: The credibility of the program will be compromised if extremely high income persons are eligible. An upper limit not less than the poverty line, nor greater than double or triple the poverty line, would address this issue.

- Eligibility limited by reason for termination from public assistance: Similarly, if the purpose is to encourage employment, then eligibility should be limited to persons who leave assistance due to employment, not those who happen to have some earnings when they leave assistance for other reasons.

- Allowability of employee contributions: Provision should be made for employee contributions to the cost of premiums for the health insurance package (e.g., similar to Michigan's One-Third Share Plan). It would be useful to provide for a sliding premium which would vary over time (e.g., lower at first, increasing over time) or with ability to pay (increasing with income).

- Freedom of choice: States should have the latitude to limit freedom of choice to selected providers, just as employers are able to. For example, a state may wish to utilize HMOs, preferred providers, a managed care network or a specific private insurance plan, which would be different from options available under mainstream Medicaid.

VII. Summary

A Medicaid extension with a different benefit structure than traditional Medicaid is uncharted ground. There is very little data on which to make assumptions of behavorial changes which will occur among recipients, providers, employers or state Medicaid programs in response to the provisions of the new program.

For this reason, the strongest recommendation I would make is that states be provided with sufficient latitude so state policymakers can use their own ingenuity to craft solutions and programs uniquely appropriate to each state's own situation.

Actually, the strongest and most sensible recommendation I could make would be for the Congress to mandate what no state can do on its own -- universal minimum work-related health coverage. If we had universal minimum coverage, then we could be talking today of a Medicaid subsidy to employers who hire welfare recipients. There would be no "cliff" issue to deal with. Instead, we must deal with issues of fairness and equity, as some employees get a benefit others don't, and as some employers choose to participate and others do not.

Until we achieve some kind of universal coverage, a sensible modified Medicaid coverage is the best we can do to ease the transition from public assistance to work.

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[1]Annual Report, Robert Wood Johnson Foundation, 1982, page 13.

[2]"MOST Employment Follow-Up Survey," Bureau of Employment Services, Michigan Department of Social Services, July 1986.

Senator RIEGLE. Joan, thank you for your patience. We'd be happy to hear from you, right now.

STATEMENT OF JOAN PHENEY, EXECUTIVE DIRECTOR, NATIONAL COUNCIL ON ALCOHOLISM, GREATER FLINT AREA, AND PRESIDENT, MICHIGAN ASSOCIATION FOR PROGRAM DIRECTORS ON SUBSTANCE ABUSE

Mrs. PHENEY. I'm Joan Pheney. I'm the Executive Director for the National Council on Alcoholism for the Greater Flint area, and the President of Michigan Association for Program Directors on Substance Abuse.

Thank you for the opportunity to present my concerns with the underinsured and uninsured citizens of Michigan.

I applaud your efforts in proposing bill S. 177 to ensure individuals have access to adequate health care insurance. You asked me to respond to what I consider to be the most present problems in housing, that I think necessary to address these problems.

Before I get into that, however, let me explain to you that the National Council on Alcoholism Incorporated provides services to people who have no insurance and for the underinsured in terms of providing a sliding scale payment available to individuals.

No one is turned away for service because of inability to pay. We, however, only provide out-patient services; and as someone who has worked in both residential and detoxification areas for chemical dependency, I can tell you that most of these services are closed to people without insurance.

If, for example, we treat someone at NCA we believe needs detoxification or residential treatment, and we believe that treatment's clinically in the person's best interest, the person may be unable to receive this treatment because they either do not have the right kind of insurance or they have no insurance at all.

Therefore, people we see are receiving treatment, if any, that is available as opposed to treatment that is best or needed for that individual.

In addition, it is important to remember that the disease of alcoholism is a chronic progressive disorder; untreated it is fatal. The average age for death due to alcoholism or its complications is around 52 years old.

Alcoholism is a generational disease, which means the devastation is passed on. Adult children of alcoholics, the population we treated at the National Council of Alcoholism, have a 50 percent higher chance than average of developing alcoholism if just one parent is an alcoholic. If both, chances are as high as 80 percent.

Alcoholism is n equal opportunity disease, affecting a complete spectrum of our population. Most importantly, alcoholism is a treatable disease. We have a number of people in our State who have been relocated because of problems in the auto industry due to layoffs and firing. Those persons, once insured, now must take low paying jobs that do not provide many benefits, let alone health insurance.

Therefore, because they are working, they do not qualify for public assistance. But, in addition, they have no benefits or health

care. We also have a number of young people who are part-time and also have no coverage.

In other words, these people are falling through the cracks of our system because they are working, have no insurance, and are unable to receive public assistance.

This is the pressing issue that you are beginning to deal with. As the economic climate changes in Flint, and plants continue to close, we anticipate a need for more services for the underinsured and uninsured.

I hope this information is useful to you. Thank you for the opportunity.

Senator RIEGLE. Thank you very much, Joan.

Mr. Brian Stork. To be followed by Ken Gunnels, followed by Andrea Lapinsky, then Roxanne Busak, James Carr.

Brian.

STATEMENT OF BRIAN STORK

Mr. STORK. Senator Riegle, I'd like to thank you for this opportunity to address you on this issue today.

I represent myself and probably a number of self-employed business persons both in the Flint area and across the Nation.

I am one of the over 40 million Americans that's underinsured or not insured at all. In my business I represent people from all walks of life. I represent the elderly, and I represent the poor. Some of them have to co-pay the $500 annual fee, some do not.

We all receive benefits at some point. My tax dollars help provide those benefits and I'm proud to contribute to their health coverage. I believe they deserve it.

I also believe, however, that I deserve it, too. I help fund their health care, and I cannot fund my own. I have a small son who was born 1 year ago, this month. We enrolled in a special delivery program at a local hospital. It was supposed to cost me $795, and that was for in 1 day and out the next.

The actual cost turned out to be $3,200, which I'm still paying. I checked into the possibility of getting health care through a group coverage, but it's going to cost my family approximately $300 a month. That's $3,600 a year, and paying cash is cheaper at this moment.

In February, I tore the cartilage in my left knee. Doctor indicated that orthoscopic sutures would be probable. However, that costs $2,500 to go in the morning to have the orthoscopic surgery, and leave later in the day. I can't do it.

In April, I tore it again. Worse this time. Now the doctor says it's definitely needed, but the answer is no. I cannot do it.

In May, I received a third tear, this the worse yet. At that point I didn't even see the doctor, because I can't. My poor elderly clients can see the doctor, but I cannot.

The poor can get jobs, but I do have clients that are poor, and some of them have reported to me that they have been offered jobs at minimum wage or somewhere in the vicinity of $4 an hour. However, they can't take the job, because this would cause a loss of their benefits in health care coverage, and it's important to them and their family. Certainly, I can understand this.

I have elderly clients who come into my office and they are unable to do anything. I work hard for the money I make. I work hard to provide those Medicare and Medicaid benefits to the poor and elderly, and I don't want it. I work even harder to provide for myself and my family, to their provisions, including needed health care.

Right now it costs too much, and I can't afford to pay for my own; and at that point, I do want it.

National health coverage would allow the poor to work and not—or enable them to get off assistance without losing the coverage and would, also, provide for me until I can get on my feet financially.

I think minimal health care for Americans is needed. Please, Senator, the American people deserve better than what we're getting, and we appreciate your efforts to improve on health care emergencies that we now face.

Thank you, very much.

Senator RIEGLE. Brian, thank you for coming. That's very important testimony, and it's very good of you to stay this long in order to make it, and I appreciate it. [Audience applause.]

I'm going to see how many folks are left here so that we can get a gauge on the rest of our time.

Mr. Gary Hankinson has come back, so we'll call on him. Where is he?

Now, let's go on and see how many we have left.

Kenneth Bells is here, and so you'll follow Gary here, but you might have come on down because you'll be the next guy up.

Andrea Lipinsky is here. Roxanne Gusap, is she here?

James Carr. Arteyal Pauline, Robert Foeyer, Marilyn Hoover, Cathy Gray. This person writes like I do.

Looks like Len Wyatt, somebody who lives on Pierson Road, in Flint.

Houston Bryant. Glenda Zafiroff, is that you, Glenda? Then you'll follow. Mary Avery.

OK, so we have about four people left and so we should be able to finish here—because I know the press people want to talk with me and some of the others, so we'll try to move on through.

Gary, you're the next person up.

STATEMENT OF GARY HANKINSON

Mr. HANKINSON. I appreciate it very much.

Senator RIEGLE. And I know everybody is attempting to summarize, and I appreciate that.

Mr. HANKINSON. Thank you.

The Clayton Stroup Foundation shares your concerns about the problems for the uninsured and the underinsured, especially as it relates to substance abuse and mental health treatment.

Alcohol and drug addiction strikes at all people regardless of age or race. Unfortunately, many people in our community will not receive appropriate treatment for the addicted diseases because of the lack of resources to aid in the care they need.

I don't plan on repeating what Mrs. Joan Pheney said but will only add that I totally agree with all the things she said about the disease addiction, specifically as it relates to the statistics.

Stroup Foundation exists to fund substance treatment for less fortunate in our community and as a supporting foundation to INSIGHT, which is the largest provider of substance abuse treatment in Michigan, servicing this last year 5,700 people in Genesee County, and more than 8,000 State wide.

In 1986, INSIGHT provided $937,700 worth of services to the indigent in Michigan. In reference to what Miss Pheney said, we are in the agency and often times, they will refer to us, and we provide the services for nothing. We are not funded for that.

This cost is absorbed by INSIGHT and to be considered to give to the community. In addition to a contract with the Genesee County Commission on Substance Abuse Services, we provide $290,000 worth of services at our community service program.

These services are significant, but they are not enough to meet the needs of the Nation, or our community. In Michigan alone, there are an estimated 750,000 residents who need services for alcohol or drug abuse problems.

Many of those who need it will not receive adequate treatment because of the lack of resources to pay for the cost of treatment. Even with the hospitals giving away millions of dollars of services as already testified to, and with our agency giving away close to $1 million, it still is not enough.

An additional $700 million cost to Michigan business and industries contribute to a loss work production resulting in chemical abuse.

Cocaine abuse is a national epidemic accounting for merely 60 percent of the admissions to addiction treatment programs.

There is an increased need for special adolescent addiction treatment. Nearly one-fifth of all admissions to State-funded treatment programs in Michigan involve youths under the age of 21.

Nationwide, nearly 5 million adolescents, or 3 of every 10 have problems with alcohol; and 1 out of every 15 kids will become alcoholics.

Also individuals experiencing a problem with an addiction to alcohol or drugs and accompanied by a psychiatric disorder, are currently undeserved due to limited funding and a lack of specialized treatment programs.

According to Health and Human Services Secretary, Dr. Otis Brown, alcohol-related problems are among the chief cause of illness and death among blacks, Hispanics and Native American populations. Half of all police arrests are for alcohol-related offenses, and alcohol use is a factor in nearly half of all accidental deaths, suicides and homicides.

The pervasiveness of chemical dependency in our overall society and community impacts all of our actions. Add to the epidemic the fact that some people are not able to receive treatment they need due to lack of insurance and is a disaster so far. Star Wars potential catastrophe, it seems to have the most legislators and the public they serve aware of this problem and seem committed to ensure us, Senator, to help solve this through their own designs that you refer to Senator Kennedy and Representative Waxman,

and the legislation provides basic health benefits for all workers. It's a noble plan that on the surface would help those who are underinsured.

The plan, as we understand it, would override State enacted mandates for insurance coverage; and it, specifically, excludes outpatient and in-patient care.

Current knowledge of whether the plan excludes substance abuse is not apparent at this time according to our recent alcoholism report dated June 8, 1987.

The plan here is simple. Legislation admits the problem needs careful examination, as you are doing here today, Senator, and inclusive of all variables so that no person is left to survive on their own. The excluded groups struggle to survive may, in fact, ruin any of the progress made in other areas, and I use the group of those who are effected by substance abuse as one possible group.

The Clayton K. Stroup Foundation and INSIGHT applaud your concern for the health care of the underinsured and uninsured. There are several policy vacuums and efforts in process in Michigan at this time which may assist in your policy development.

We recommend your committee review this information before any legislation is proposed.

Thank you for this opportunity. We are more than happy to work with you in the future. We thank you again for this opportunity to voice our opinion. [Audience applause.]

[The prepared statement of Mr. Hankinson follows:]

Clayton K. Stroup Foundation

June 20, 1987

Honorable Donald W. Riegle, Jr.
910 Sabuco Building
352 S. Saginaw
Flint, MI 48502

Dear Senator Riegle:

Thank you for offering the community and our organization the opportunity to present information on policy development for uninsured and underinsured individuals.

The Clayton K. Stroup Foundation and Insight share your concern about the problems with the uninsured and underinsured, especially as it relates to substance abuse and mental health treatment.

Alcohol and drug addiction strikes at all people, regardless of age or race. Unfortunately, many people in our community will not receive appropriate treatment for the disease of addiction because of the lack of resources to pay for the care they need.

The Clayton K. Stroup Foundation exists to fund substance abuse treatment for the less fortunate in our community.

Insight is the largest provider of substance abuse treatment in Michigan servicing this last year 5,700 people in Genesee County and more than 8,000 statewide. In 1986, Insight provided $937,700 worth of services to the indigent in Michigan. This cost was absorbed by Insight, and can be considered a gift to the community.

In addition, through a contract with the Genesee County Commission on Substance Abuse Services, Insight provided $290,000 worth of services at its Insight Community Services Program in Flint to those unable to afford substance abuse treatment services.

In Michigan alone, an estimated 750,000 residents need services for alcohol or drug abuse problems. Many of those in need will not recieve adequate treatment because of the lack of resources to pay for the cost of treatment. Our efforts have been substantial but not adequate.

Chemical abuse results in an estimated $2 billion drain on the Michigan economy in terms of financial and human costs. An

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additional $700 million cost to Michigan business and industry is attributable to lost work production resulting from chemical abuse.

Cocaine abuse is a national epidemic accounting for nearly 60% of admissions to addiction treatment programs in several Michigan cities including Flint.

State and federal funding for the human service sector, including alcohol and drug treatment agencies, continues to decline in spite of the growing need.

There is an increased need for specialized adolescent addiction treatment. Nearly one-fifth of all admissions to state-funded treatment programs in Michigan involve those under the age of 21. Nationwide, nearly 5 million adolescents, or 3 of every 10, have problems with alcohol and one out of every 15 kids will eventually become alcoholic.

Individuals experiencing a dual diagnosis--an addiction to alcohol or drugs and accompanied by a psychiatric disorder--are currently underserved due to limited funding and a lack of specialized treatment programs.

According to Health and Human Services Secretary, Dr. Otis Brown, alcohol related problems are among the chief causes of illness and death among black, hispanic and native american populations. Half of all police arrests are for alcohol related offences and alcohol use is a factor in nearly half of all accidential deaths, suicides and homocides.

The pervasiveness of chemical dependency in our overall society and our community impacts all of our actions.

Add to our epidemic the fact that some people are not able to receive the treatment they need due to lack of insurance and a disaster of catastrophic proportions seems inevitable.

Most legislators and the public they serve are aware of this problem and seem committed to help solve it through their own designs.

For instance, Senator Edward Kennedy and Representative Henry Waxman are introducing legislation that will provide basic health benefits for all workers. A noble plan that on the surface would help those who are underinsured.

However, the plan would override state-enacted mandates for insurance coverage and it specifically excludes mental health outpatient and inpatient care. Current knowledge of whether the

plan excludes substance abuse is not apparent at this time according to the Alcoholism Report of June 8, 1987.

The point here is simple. Legislation to fix a problem needs careful examination and inclusion of all variables so that no group is left to survive on their own. The excluded group's struggle to survive may in fact ruin any of the progress.

The Clayton K. Stroup Foundation and Insight applaud your concern for the health care of the underinsured and the uninsured. There are several policy documents and efforts in process in Michigan at this time which may assist in your policy development.

At a time convenient to you and your staff, we will be happy to discuss these efforts that are occuring locally and on a statewide basis.

Thank you for this opportunity to voice our opinion.

Sincerely,

G Hankinson

Gary Hankinson, Director
Clayton K. Stroup Foundation

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misl/letrie

Senator RIEGLE. Ken Gunnels. Let me say to all of you that are testifying at this point in the morning, or mid-afternoon, now, I appreciate that you're here, and that you've waited so long. I know that's not easy to do, but I'm very appreciative of the fact that you've waited to testify.

STATEMENT OF KEN GUNNELS

Mr. GUNNELS. I appreciate that we've stayed here this long, too. I think I should be out there working today.

This fella', Stork, that was up here, he almost told my story. I'm an independent contractor. I live in Clio with my wife and 7 year old son.

I only thank God that I don't have a horror story to report like some of these other people have.

I am uninsured. We live with this little fear that right around the corner something could happen. I have investigated insurance programs. People call my house and try to sell me insurance.

Number one, their premiums are right straight through the ceiling, and they don't offer you a program like General Motors has, or anything like that. They offer you things that—with so many different hedges in them; and by the time you're done talking, you're left with this feeling that unless you get run over by a herd of elephants on Christmas Eve, you're not going to get covered.

I don't want charity. I am more than happy to take care of my family. That's why I go to work. But, I mean, it's like wearing braces on my teeth. I can take that, and if he needs medical help, I can probably pay for that. But, you know, you always worry about, well gee, what if—you hear about these bills that are $250,000.

I invite you to work as a part of the American dream. You know, that's why I work sometimes from 6 o'clock in the morning to 9 o'clock at night, and I save a little money, and I work for that; and, then, something like this happens. It's all—it's just gone.

In this community, unless you work for General Motors, or unless you're totally indigent, then, there's no place for you; and you can pay your taxes, and you can give the citizens, but when it comes time that you need something, well, you're not poor enough to get any help from here, or you're not at the top to get the other benefits that people have.

One thing that I think that's—like the people who work for General Motors. Their health insurance is paid for. They don't pay income tax. I think it's an insult to people that don't have health insurance that need their health insurance tax deductible. It seems like every penny they can spend on health insurance, at least you can want your income tax returns.

It's bad enough when you've got the coverage and something like this, and you know right here I've heard Star Wars blasted pretty heavily in this meeting, and I'm like not in favor of that, but that $1,600 policy has got to stick in a guy's throat, too.

I've seen the issue here on Nightline News you have—you don't have to worry about—talked about the martian plans a few years later; and here is this man who owns a vineyard in Italy, being waited on by butlers and maids, you know?

We've poured millions of dollars in something like that, and his son is driving a Porsche, and, you know, then you see this guy with one leg walk by—driving it. That's an insult. That is an absolute insult.

So, I mean, I think, if we could just round up some of the waste we have, you know; but I don't if I will favor, point blank governmental plan. I think that we should—there should be incentives for people who try to stay well and to not just, you know?

I think, this think can be abused; and, as I say, I don't want these people who mooch on the government, the people of the government, I don't want these people to pay for my son who gets a cold or has to have a vaccination shot or something like that.

My gosh, that's why I had him, and I'm proud to take care of him; but, I think, if you put something in there, where we've got to—say well, that you work hard and do the things that we were all taught when we were children, are good.

And, that's all I have to say, and——

Senator RIEGLE. I think you've said just about everything that needs to be said. I think that's a terrific statement, and I can't tell you how much I appreciate your coming and spending the time to do it; and you, also, like the other fella' that you mentioned, represent self-employed people, who even though you're self-employed, and I think that reminds a lot people, that would mean, that, you know, presumably——

Mr. GUNNELS. Oh, yeah, you're rich.

Senator RIEGLE. Sure, you're rich and you've got your own health insurance and so forth, as you point out, you're not able to afford health insurance and if you get hit with the big medical bills, you're in a position where you could lose everything overnight.

Mr. GUNNELS. Four years ago I—we were involved in a very serious accident. Serious enough that TV 5 came out and covered it, much to my embarrassment.

Senator RIEGLE. TV 5 is everywhere. Jim Rush and Bobby and the rest, you can't——

Mr. GUNNELS. A contractor was working on his own home, and has an accident. That's good publicity. Call a merchant and guy gets hurt building his own home. Right?

They came right out after I gave word to the hospital. After a week in the hospital—I mean, this was a serious enough accident that I would probably be retired from General Motors. Certainly I would have gotten a year off for sick days.

The day they wheeled me out of the hospital was the day I was back to work because in my work you either work or you're stuck; and you know, I don't want a freebie? You know, I would like something like a major medical or something where you just say, "Hey, you know, you people pay a thousand dollars," if it was possible to structure.

So you can afford to pay $2,000 you know, I mean—if the life of my child depends on it, I can come up with $2,000.

You know, but, you know, $250,000——

Senator RIEGLE. Well, that's exactly what we're working on. We're going to try to get it done for you.

I'll say that could change, too. Well, I appreciate you being here, I really do. I am really impressed. [Audience applause.]

Andrea. Jim Carr, you'll be next. You may want to come on down here, so you're ready to go here.

Andrea, nice to have you.

STATEMENT OF ANDREA LAPINSKY

Miss LAPINSKY. My name is Andrea Lapinsky and I'm 27 years old. And I'd like to say that I am employed at a local food chain in the area, and I do not have any health insurance with that company.

Last year, I went into the hospital with severe abdominal pain, which I thought was going to be taken care of in a matter of days. I ended up staying there for 4 weeks.

I was out of work for 8 weeks. The diagnosis I had was Chole's disease, which is an inflammatory bowel disease, and it's a chronic disease. I will have to be treated for the rest of my life.

While I was in the hospital, I figured, "Well, I don't need that much money. Social Services will take care of it." The day I got out of the hospital I made an appointment to see Social Services. Along with many other people, they are not senior citizens and they're not minors, and my disease was not totally disabling.

So I was not—I did not receive any benefits from the Department of Social Services. On top of all that, Hurley Hospital sued me for the amount of the bill, that was much in excess of $18,000 for treatment.

Senator RIEGLE. Over $18,000 for 4 weeks of care.

Miss LAPINSKY. And, so, I did something some people consider drastic. I filed bankruptcy. Last year my gross income was $6,500. There was no way I could pay that much money back to them in any amount and I had to take medication daily, I had to see the doctor periodically.

For two of them I probably will have to have done later on in the year, that's $1,000 just for the examination, just for the tests.

I think, that if there had been a National health care type of thing organized at that time, I would not have had to take those drastic measures, filing bankruptcy; and I hope and pray that I will not have to go in the hospital again, within the next 7 years, or else I'll be in worse shape than I was before, as far as financially.

I appreciate you giving me the chance to come out here and speak, and I really do hope that you can learn from my story that how a system like that can help people help themselves.

Senator RIEGLE. Before you leave, let me say that it's so important that you come and testify, and I'm deeply appreciative that you have because I think people don't understand that these things can happen to younger people, such as it happened to you.

You know, we tend to associate catastrophic health care problems with senior citizens just because we tend to think of it all in that way.

The fact is, that there are a lot of younger people, like yourself, that get hit, and for you to have bills in excess of $18,000 in just 4 weeks for something you didn't even know you had, I mean, you just went in thinking it was a minor problem and now you not only found out that it was a very major problem, but it's something you've got to live with, you know, on into the future.

In our legislation, however we find the indepth adjusting it is aimed exactly at your situation because it's our feeling that there are thousands of thousands of thousands of people just like yourself, and it could be any of us because it's—what determines who gets sick and who doesn't? It's a random thing, and so, we've got to have an insurance system in place.

You shouldn't have to go in bankruptcy. You know, you're out working and you're working hard, I'm sure, you know, you're expending a terrific effort to earn that $6,400 a year. So, we need to have you continue to work.

It's the effort, and you need to work to make the income, and so forth. So, we're going to do what we can to see that we get this into place.

Miss LAPINSKY. I just have one question, it just came to my mind as you were speaking.

A lot of insurance companies, for example, if I was to be able to afford to go out and buy insurance, they don't cover for illness prior to the time you pick up insurance. Now, would something like this that you're working on, would that include me, like if I, if my——

Senator RIEGLE. Yes; that's one of the virtues of the system, like this public system, because we can draw it in a way that's different than a private system would to it.

A private system where they're going to try to make a profit, with their policy coverage, because you walk in the door with preexisting problems, they're going to treat you differently, and our approach is to pick up all the problems around you.

Miss LAPINSKY. Well, thank you very much.

Senator RIEGLE. Thank you, good to have you come. Mr. Carr.

STATEMENT OF JAMES D. CARR, SOCIAL SERVICE DIRECTOR, THE SALVATION ARMY

Mr. CARR. The Salvation Army has been here for 94 years, in any case. I appreciate your coming. I am, also, glad that many of those who are personally touched in that area were here to testify.

Sometimes I sit in my office, and I say to myself, "I sure wish those people in Washington could sit in my seat for a day and watch the people come through in need." It would change their priorities.

I'm sure glad that you're here to hear testimony concerning that. We believe, that an improved health care system is essential to our citizens. We see so many in need. I'm particularly concerned with two areas.

One, is the rolling number of employees that you've heard about here without health insurance, who are unable to receive Medicaid, and they are in tremendous need. They have worked, they get along as long as there isn't crisis, but the minute there is a small crisis; to go to the doctor, some medical bills come up, they just don't have the resources behind them to cover those areas.

Consequently, they go without medical services that they need, or else they borrow from their food and shelter monies to pay the medical bill, and, then, come through our door asking for food and shelter money, and in relation to that, I would like to thank you

for your supportive program, which is one of the best programs that we have probably in this county.

This prevents hunger and homelessness, and we appreciate that money to help us serve in those areas. It's very closely related, I feel, to health because good nutrition and shelter and facilities and water and sewer; and those areas are very important in those areas, as well.

So, we thank you for the concern you have. Also, concerned that any program that you have in guaranteeing some medical assistance for those who need prescriptions to keep from life threatening situations.

You have heard here earlier testimony concerning the one who was epileptic, the one who was on the seizure control medication. I'm concerned about those people that are diabetic that need insulin, those that have heart problems who need medication for their heart to keep them from having an attack.

We need to understand that those are not optional to those people. Those prescriptions, if some of them even go for a day or two days, it could present a life threatening situation to them.

Any medical program, I would hope, would address the severity of that situation to prescription drugs for those people.

I would like to say in conclusion, I would support those measures that would ensure individuals access to adequate health care, that ensures programs, and services to the poor.

Thank you.

Senator RIEGLE. Thank you, very much.

Glenda, to be followed by Mary Avery, and, then, I think we're finished.

STATEMENT OF GLENDA ZAFIROFF, PRESIDENT, GENESEE COUNTY ALLIANCE FOR THE MENTALLY ILL

Mrs. ZAFIROFF. Senator Riegle, platform guests, the press, and citizens, I am president of the Genesee County Alliance for the Mentally Ill. [Crying.] I am an out-of-the-closet mother who has a son who is Manic Depressive. I always think I'm through crying over the years, but when I think of the mentally ill, it should make everyone cry.

The health needs for the mentally ill is really a sleeping giant, for families who have kept silent about the disease. The health care for the mentally ill is deplorable.

I had a lady call me and said that the psychiatrist said her daughter had to be in the hospital for private care, and it cost $35,000, and the mother says, "We cannot afford it."

I say, "Just go to your community mental health system. It's poor, but it's all we have." My own self prescription is therapy, and therapy is advocating for the county program for the mentally ill and their families. Psychiatrists talk about a variety of psychological abnormalities that disrupt the brain activity, but mental health professionals, judges, legislators, and the general public continue to believe major mental illness results from psychological weaknesses and an inability to cope.

That the chronically mentally ill could recover if they would just really work at it; a wasted life of being mentally ill cannot be in

vain. Something positive needs to emerge from the pain and suffering inflicted on them and their families.

I do hope to see a change that guarantees that the next generation will not experience the anguish and frustration of a mental health system and a legal system that do not meet their needs.

Research, housing, work, and health care for the mentally ill is a must, for all of society to advocate for because, do you know, it could even save our tax dollars if it was the right kind of help?

I'm sorry for the tears. I usually think I'm all cried out, but, I guess, I never will be.

Thank you.

Senator RIEGLE. Thank you. [Audience applause.]

I appreciate what you've said and the feeling with which you say it, and unless people within the sound of your voice had had to deal with problems of mental and emotional illness, and I have, myself, so I've seen it at close range. They can't begin to understand what that's like.

So, it's very important that you come and testify that way, and I appreciate it. I know it's not easy to do, and I see your tears as tears of courage and strength and love, and, so, we're just proud that you were here and that you spoke, and that you gave us that valuable testimony.

Mary Avery.

STATEMENT OF MARY AVERY

Mrs. AVERY. Senator Riegle, I thank you for the opportunity to come here and speak. On behalf of one of the thousands that you was talking about a while ago, I'm under 62, and I have that problem of not being able to get help financially, you know, because Medicaid is up there.

Unfortunately, I can't wait until fall 'till I'm 62. So, I have really had the problem even before my former marriage. After my husband died, I had no insurance.

Since I have been married to my husband, now, we live in Flushing, and we're on Social Security. He has Medicaid and Medicare, but I don't; I'm not old enough yet. But, recently, 2 years ago, I had a problem of falling.

I had my leg in a cast for 8 months, and, fortunately, then, I was able to get help from a doctor. That did take a lot of money getting healed over that 8 months over that.

Just 4 months ago, I fell in the store and slipped and fell on water, and I have really hurt myself in different areas, and the hospital costs and financial cost is tremendous.

I mean, the doctors want you to go and get all these tests taken, and right now, there's three or four tests they want to do, and one costs $800 and the other $500, and like that.

I had a problem when I first got hurt going to a doctor because I didn't have one. When I went to him, unless you got cash, when you're involved in a situation like this that involves an insurance company, they don't want it, they want cash.

I tried to get them to, you know, I had a letter from a lawyer, I had gotten everything saying that they would get their money first when the case was settled, and that; but, they didn't want to do it.

If you could come up with some kind of a financial system so that people that are in that situation like I am, they could get financial help to pay for all these expenses until their money comes in, which they would get reimbursed for.

It don't make any difference, and it has caused a lot of stress on me. The Bible and my faith in God in the past 4 months is what has kept me going. I try to smile and stand above it, and even though I have been hurt, and they have even found the things that I didn't even realize I had wrong with me.

That had no connection with the insurance. I mean, from the slip and the fall; but, what do I do? I mean, where do I go for the money? I can't seem to find any place to receive help for, and I just was glad for the opportunity because I felt so many times, something should be done.

I'm not the only one. That girl ahead of me that just spoke, there must be, like you said, hundreds and hundreds of people that are under that age that need this financial help that can't afford insurance.

We tried to get Blue Cross, and, I mean, it's a hundred dollars a month just for me to have it each—you know—to have it. Of course, falling like this makes you realize how much you really need insurance because it's important—extremely important that this insurance is provided for people.

Another thing, while I was laid up that 8 months, I just prayed for something to do with my hands. I had to sit all the time to keep my legs elevated, and everything.

So, I come up with this idea of making greeting cards, and they're beautiful, and they're great. But, here's a financial situation again. I don't have the money to—I could get them out on the market if I could hire somebody to help me make them, even in my situation right now, while I still have to go to a doctor, and everything.

I could do these things to help myself.

Senator RIEGLE. Right.

Mrs. AVERY. But, here's that financial situation. If I had help there, I could make my—I had five dozen orders at Easter time, which I couldn't even make.

I mean, you know, this is the situation. I'm sure all over, the financial situation is there, and everything, but I feel that if there was something provided for people that are under 62.

Like, that girl was a lot younger than I am. I hope she don't have to go through what I do up until she's 62. It's a traumatic situation. Something needs to be done to provide and help, like, other sides.

We pay our taxes, and I'm grateful it's helping others, but what do we do when we need help ourselves?

Senator RIEGLE. Well, you know, your testimony is so important, and I appreciate it. In a sense, you've sort of summed up the whole thing right here with your remarks and other witnesses that have just come before you here, and that is that we've got a problem out there, and it's a very serious problem.

It hits you. You go into a supermarket, things seem to be OK at that moment, and, then, you had an accident, and suddenly in your

situation, your life was changed, and that's happened to people all across the society of all ages.

You see it in the form of cancer. Ted Kennedy tells the story about his son, who was stricken with cancer and had to have his leg removed. He survived and appears to be healthy now, but after tremendous medical bills.

He was fortunate enough to be of a family with the means to be able to pay those bills. But, that could be anyone's son. It could happen to any adult. It could happen to anybody of any age, as it has happened to you.

That's why we're committed to get this legislation passed. The reason we're holding this hearing is to gather the evidence, just as you brought the evidence today, to build the record, to gather the facts, to be able to build the record, to be able to take the facts back to the other members in the Senate, to discuss what the problem is, to use this as a basis to try to get the wheels turning so we can get these things done.

We should have legislation like this in place now. It should have been done years before now.

Mrs. AVERY. That's right.

Senator RIEGLE. We've got to get it done, and we're going to do our very best, and your testimony today is going to help us.

Mrs. AVERY. I'll do anything I can to help.

Senator RIEGLE. We thank you for coming today, and you've helped a lot.

Mrs. AVERY. I have felt so many times that if something don't happen, I'm going to Washington.

Senator RIEGLE. Well, Washington came to you.

Thank you, very much. [Audience applause.]

Well, we appreciate the testimony of everybody that's spoken, and we're going to adjourn the hearing now, so we're in a position to talk to others if they have comments to make.

Anybody else who wants to read any testimony today, before they go, we'd be welcome to receive it now, or in the very near future, so we can insert it in the record.

I thank you for coming, and this hearing is now adjourned.

[Whereupon, at 1:47 p.m., the committee adjourned.]

JUN 25 1987

Adult Foster Care Providers
of Genesee County, Inc.
P.O. Box 79
Flint, Michigan 48501

President - Marlene J. Maxfield
Secretary - Eunice Capen
Vice President - Norma Burns
Treasurer - Judith Gorte

June 23, 1987

Senator Donald W. Riegle, Jr.
c/o Jill Laitur
Sabuco Building, Suite 910
352 South Saginaw
Flint, MIchigan 48502

Re:Public Hearing on Health Care Issues

We did not receive your letter until yesterday as I was away on my vacation and consequently missed the hearing.

There are two areas of concern we have as Adult Foster Care Providers.

1) Residents who receive adequate social security to just barely meet their room and board amd do not have money left to pay doctor bills and/ or medical insurance. They do not qualify for Medicaid,and Medicare does not cover adequately.

   They must use their small amount of personal monies for medical needs.

2) Many residents require dental care more frequently than allowed under medicaid and must pay out of their personal monies.

Another comment we have is that medicaid does not adequately cover medications. The resident must pay the 50-cent co-pay and sometimes the entire amount of the prescription. We feel that all medicaid client prescriptions should be covered.

Respectfully yours,

Marlene J. Maxfield

(Mrs.) Marlene J. Maxfield, President
218 W. Fourth Street
Flint, MI 48502 (313) 232-7433

WESTERN REGION
950 28th Street S.E., Building E.
Grand Rapids, Michigan 49508
(616)243-8477

American Diabetes Association

MIDEASTERN REGION
G-3508 Beecher Road, Suite A
Flint, Michigan 48504
(313) 732-3085

MICHIGAN AFFILIATE, INCORPORATED

Clauson Building — North Unit • 23100 Providence Drive — Suite 475
Southfield, Michigan 48075 • 313/552-1580

June 17, 1987

Hon. Donald W. Riegle, Jr.
c/o Jill Laitur
Suite 910
352 S. Saginaw St.
Flint, MI. 48502

Senator Riegle:

My name is Sandy Burgis and I am the Regional Director of the American Diabetes Association - Michigan Affiliate, Inc.

Regarding Senate Bill S. 177:

The most pressing problem in health care today is no health insurance or inadequate health insurance for people with a major medical problem

Diabetes is the perfect example of a disease where people cannot obtain health insurance. Insulin, syringes, and other supplies are a "must" for people with diabetes. They must take their insulin or they die.

They can also experience health complications that necessitate a hospital stay. These expenses stay constant. There are no bargains or discount sales.

The people with diabetes in the State of Michigan need help. They need to have insurance that picks up at least a part of the medical expense.

The people that hurt the worst are not the ones on welfare. They are the ones who are in the middle; trying to work to support themselves and their families. They make a wage, but

are entitled to no benefits. I am enclosing a letter that is just one of many our office receives.

Thank you, Senator Riegle, for realizing this problem does exist and for addressing it.

Sincerely,

Sandy Burgis

Sandy Burgis
Regional Director

1123 S. Third St.
Chesaning, MI 48616

Dear Don,

Older people are not the only ones who need help with their medical coverage!

Three years ago, Joe lost his job (of 28 yrs.) when Midland-Ross in Owosso closed the plant. We continued our Blue Cross group coverage through the Union local. Since then, it has gone up from 180. to 220. to 310. per month (2 people). That last increase was $90. per month at once! Unreal.....

Needless to say, we were no longer able to afford that. Joe has not found a permanent job, and I work 30 hrs. a week where I have no medical coverage. I have had to take out a policy on myself. Very fortunately, Joe is a veteran so is able to get medical service from the VA -- and President Regan wants to cut their funds--

We will not be able to attend your hearing, so this will give you an idea of our particular situation. I suspect there are many others that are similar. Naturally we agree that something definitely needs to be done. Something should be worked out because the high cost of medical care has caused insurance rates to be so high, yet you can hardly afford to be without it. I wish I knew what could be done to solve the problem, but I really don't know what the answer is. I just hope enough good ideas put together will be able to do it.

Sincerely,

Elaine Amman

Mrs. Joe (Elaine) Amman

GARY MAJESKE
BAY COUNTY EXECUTIVE

515 CENTER AVENUE
BAY CITY, MICHIGAN 48708
TELEPHONE: (517) 892-6535

Bay County Building
Erected 1932

August 11, 1987

Ms. Joan Huffer
Office of Senator Donald W. Riegle, Jr.
105 Dirksen Senate Office Building
Washington, D.C. 20510

RE: Health Care Issue/Uninsured & Underinsured Individuals

Dear Ms. Huffer:

Pursuant to Senator Riegle's letter dated July 15, 1987, inviting comments on the above-mentioned issue, I respectfully respond via this written communication.

Key insurance concerns for seniors are 1) prescription costs and 2) cost of basic care in a nursing home.

Prescription costs are only 6.5% of total health care costs and through prescribed drugs, many ailments are treated, thereby avoiding hospitalization; yet medicare and most non-group supplemental insurance policies do not cover prescription costs.

The average nursing home stay is 3½ years - basic, custodial care. The average skilled care nursing home stay is twenty days. Very recently the private insurance companies began providing long term care policies which cover $10 to $100 per day for basic care up to three years. Unfortunately many seniors can not afford this type of policy in additior to their supplemental health insurance.

If medicare would start to cover prescription costs and basic care, perhaps charging all medicare recipients $35 to $50 a month would eliminate the need for a deductible. As of now, statistics show that 20% of seniors aged 65 to 85 go into nursing homes for basic care, but the percentages increase with 85 plus, which is the largest growth segment for senior population.

For seniors 60 to 65 years of age, obtaining health insurance with reasonable coverage and cost is very difficult; so many go without, until medicate begins at age 65. In Michigan, Blue Cross/Blue Shield is the only company currently enrolling 60-65 and usually with preconditional coverage.

Should you desire additional information, please contact me.

Sincerely,

Gary Majeske

Gary Majeske, Bay County Executive

GM/jz

EDWARD S. BERNREUTER, M.D., P.C.
PRACTICE LIMITED TO UROLOGIC SURGERY
1320 NORTH MICHIGAN AVENUE
SAGINAW, MICHIGAN 48602
TELEPHONE (517) 752-7941

10 August 1987

Donald W. Riegle, Jr., Senator
United States Senate
Washington, D.C. 20510

Dear Senator Riegle:

In response to your request for written testimony on the hearings regarding health insurance for the uninsured and underinsured, it is my strong belief that the efforts of the deficit-ridden Federal Government would be better directed towards creation of meaningful jobs and employment for all Americans rather than creating another federal program and the bureaucracy associated with it. This country needs to be put back to meaningful work and to rebuilding its agricultrual and industral base and if these things are attended to, the need for this kind of program would not be necessary and all of us would be better off. This revivial of America can only take place with Federal money at low interest rates with the aim of taking us out of the poverty of the so called service economy which can only result in a lower standard of living for all of us.

This country is in a severe depression inspite of the so called, "Reagan recovery" and only the measures of the 1930s are going to revive this sick economy. Our infrastructure of bridges, railroads, etc., is rotting away and these symptoms of a sick economy should be the primary concern of our government. I would also like to state that the problem of AIDS makes the issue of health insurance insignificant by comparison and that the Federal Government has delayed action far too long. America is loosing its leadership and industry, agriculture, science and technology and I urge everyone with power and influence to put us back on tract in these areas.

Sincerely,

Edward S. Bernreuter, M.D.
D.A.B.U.

ESB/lar

Dr. Ralph Wm. Burgess
3380 South Dye Road
Flint, Michigan 48507
(313) 732-1450
Aug. 11, 1987

Joan Huffer
105 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Joan:

Thank you for the opportunity to speak on the subject of health insurance for the uninsured and underinsured in Flint. As you are aware, Flint has a very large percentage of people with excellant insurance coverage due to G.M., the public schools, city and county employment etc. I believe when you talk about uninsured or underinsured in the Flint area you are talking about three main groups of people; 1) the self employed 2) the poor or unemployed and 3) the elderly.

The self employed, such as myself have many obstacles to overcome in their yearly business dealings and one is clearly the cost of health care insurance. It appears to be readily available if you can afford it. Luckily I am in a position that I can do it but I am sure it is a hardship for many.

The poor and unemployed often do without. As a dentist, I can say their care often is as of a last resort rather then keeping up their oral health. State funded help such as medicaid is of little value and often pays only for extractions. Most dentists don't accept it (medicaid) anyway because of mountains of red tape, poor reimbursement and lack of good common sense (fillings are not covered just extractions).

The elderly are much the same. Medicare does not cover dentistry. I understand there are even large gaps in the medical coverage. Because of this, often an elderly patient does not get the dental care as they should.

I believe some dental provisions should be added to medicare coverage and, also medical health coverage should be improved. The harder question is what to do with health and dental coverage for the poor? Possibly expanded services with medicaid or even some state or federally funded clinics.

I do not believe that a federally funded and regulated health care program is the answer for <u>all</u> people. It could reduce freedom of choice type care and that surely could result in overall lessaning the quality of our nations health care. Also programs and legislation that would ease the overhead burden of our health care providers could have a positive effect decreasing the cost of health care. Such legislation as laws to decrease the burden of malpractoce insurance premiums by limiting the awards given in cases to a more realistic compensation. I believe not only in health care but in most areas of american life the cost and fear of being sued has had a very negative effect on both cost and services. Secretarial cost increase as more time is devoted to expanded legal record keeping. Equipment costs escalate

Dr. Ralph Wm. Burgess
3380 South Dye Road
Flint, Michigan 48507
(313) 732-1450

as healthcare providers buy more and more machinery often just to produce several pieces of "evidence" for the procedures they have done. Malpractice premiums multiply each year.

I think finding ways to make healthcare more affordable such as legal reform would have a beneficial effect for care of the needy. Also additional programs within state (medicaid) and federally (medicare) funded programs would aid in improving healthcare to the uninsured and underinsured.

Sincerely,

Ralph Wm. Burgess D.D.S.

Ralph Wm. Burgess D.D.S.

CENTRAL MICHIGAN
COMMUNITY HOSPITAL
YOUR PARTNER FOR HEALTH

1221 South Drive
Mt. Pleasant, MI 48858-3234
517 772-6700

JUN 21 1987

June 16, 1987

Senator Donald W. Riegle, Jr.
Sabuco Building, Suite 910
352 South Saginaw
Flint, MI 48502

Dear Senator Riegle:

The following is in response to your letter dated June 3, 1987 regarding the Senate hearing on health care issues to be held on Monday, June 22.

When exploring the health care issue of uninsured/underinsured individuals, it is necessary to examine the impact on both the providers of health care and on the uninsured/underinsured individuals themselves. In an attempt to briefly address this issue, I would like to share our experience in hopes that the problems can be better understood and solutions can be found.

Central Michigan Community Hospital (CMCH) is the sole provider of hospital services in Isabella County, Michigan. Approximately 19% of the residents of this county are below the national poverty level. As the result of a high percentage of county residents being unable to afford adequate health insurance, CMCH provided $615,423 of charity care in 1986. This is a 38.2% increase over 1985, which indicates a growing problem. In addition, CMCH wrote off $1,661,673 in Medicare and Medicaid charges in 1986, an increase of 188.5% over 1985. (Medicare represents 41.6% of our patients and Medicaid represents 15.2%.) As the result of reduced reimbursement and/or no reimbursement for some of the uninsured and underinsured, we are forced to pass those costs on to other payors or absorb the loss ourselves. This threatens our ability to remain a viable entity and it is not likely that we will be able to continue passing these costs on to other payors in the future.

In our daily interactions with patients, we are made aware of many of the hurdles that individuals encounter in attempting to obtain proper health insurance and health care. In 1984, almost one in six

Americans (over 35 million people) had no medical insurance according to the census bureau. That was up 22% from five years before. An estimated 65% of those without medical coverage were working or were the spouses and children of workers. The problem is that many small businesses do not, and possibly cannot, afford to provide health insurance to their employees. That is the situation in Isabella County where we rely upon small businesses to provide jobs due to the lack of major industry.

Another problem facing our patients is the increasing Medicare deductible. Medicare recipients are finding it increasingly difficult to meet the deductible. In addition, they are often under the impression that their third party coverage will cover the deductible, when in many cases it will not. It is also increasingly difficult for patients to qualify for Medicaid. Budget pressures have forced the Reagan administration to reduce the percentage of poor people covered by Medicaid from a high of 63% in 1975 to about 46% in 1985.

The issue of the uninsured/underinsured individual is a very serious problem with no easy answers. Failure to address the problems and to seek solutions will have a very negative impact on the viability of many hospitals and on the health of many individuals.

I will not be able to personally attend the Senate hearing on health care issues next week, but I do appreciate the opportunity to respond to this growing problem. We, too, are very concerned about the problems with the uninsured and underinsured, and support you in your efforts to find a solution to this ever-increasing dilema. I am hopeful that this letter, though brief, will be beneficial in the understanding of these problems from the perspective of a health care provider.

Sincerely,

Paul K. Halverson
President

PKH:vlt

FAMILY AND PERSONAL STRESS CLINIC

(West Flint Clinical Associates, P.C.)
1012 Professional Drive, Ste 1075
Flint, Michigan 48532
(313) 732-3650

James T.S. Rhyee, M.D.
Medical Director

Gregory M. Hillaker, MSW, CSW
Managing Director

8-11-87

Senator Donald W. Riegle, Jr.
c/o Joan Huffer
105 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Sen. Riegle and Ms. Huffer:

We at Family & Personal Stress Clinic are committed to providing a high quality professional service to our community and the area around it. At times, the constraints of the health insurance environment in which we operate create difficulties that interfere with the expression of this commitment. The numbers that we can generate to document the quantitative impact in the community or the financial burdens faced by ourselves may seem impersonal, so we have decided to outline a few "real-life" cases that demonstrate some of the obstacles faced by our professionals and the people we serve.

A) A 19-year-old male college student without independent income has been shuttled between divorced parents because of his violence toward each of the parents and antisocial acts toward others in the community. The diagnosis of Borderline Personality Disorder, supported by psychological testing, would normally be expected to require long-term intervention and psychiatric support, but the young man withdraws from one of the rare constructive social contacts in his experience because his non-custodial father's health maintenance organization will authorize no more than 10 sessions of treatment.

B) A 40-year-old mother of four and stepmother of three began to experience confusion about time (reliving traumatic events that occurred 20 years ago) and people ("seeing" and talking to people she "recognizes" from many years ago who report never knowing her), becoming depressed and adding to family strain. Treatment authorized by her Health Plus coverage is currently limited to 7 more visits, to be shared by the psychotherapist and the psychiatrist, for a suggested Schizophrenia diagnosis.

C) A 30-year-old man referred to us because he "spanked" his daughter until she bled carries a provisional diagnosis of Paranoid Personality Disorder (R/O Intermittent Explosive Disorder). This is especially disconcerting in light of the fact that he is skilled in and has ready access to sophisticated weaponry, and complicated by the fact that his family physician was, and continues to be, reluctant to authorize ongoing treatment that would be paid for by Health Plus.

D) A 27-year-old woman who was suicidal was told by her primary physician to "get on your knees and pray" and denied a referral which is required to take advantage of her insurance coverage. She came in to treatment with borrowed money and has made dramatic progress in overcoming a Cyclothymic Disorder despite the less-than-ideal session

frequency based on her financial situation.

E) A young couple seeking marital counseling is told that their insurance coverage will pay for the diagnosis and treatment of individual problems, including an accident-related injury to the husband's brain that results in erratic emotions, but not for marital treatment.

F) A 32-year-old woman whose family has an extensive history of psychotic behavior experiences similar problems in her own life that result in her placement on sick leave from her workplace. Due to the chronic nature of her difficulty and the fact that ongoing outpatient has exhausted her limited insurance coverage, she is faced with a choice to limit treatment at the time when she requires more support or take on additional financial burden when she is without her usual income.

G) A young mother of two, divorced from a husband who abused her and the children, discovers at the time that she graduates from college that her hopes of getting off public assistance will have to wait. Her 9-year-old daughter requires tube-feeding for 14 hours/day, and her 7-year-old son has a neurological problem that likely has existed since birth. The child has been seen but inadequately served by organizations that accept her Medicaid insurance, but she has limited choices in selecting better service because most organizations choose to avoid the problems of incomplete and delayed payment that Medicaid provides. We are currently providing service characterized by a full psychological battery of tests for $5.00 but our ability to do this and remain financially solvent is limited.

As you may surmise from the above, we find it simultaneously difficult and desirable to balance the priorities of quality professional service and the financial stewardship that allows this to continue. This already formidable task is complicated by the insurance companies' practices of contracting rates at discounts from "standard" fees: if we make it a practice to provide services at reduced fees for those individuals without insurance coverage or the ability to pay at full fees, the insurance company may conclude that the "standard" to which they key their payments is much lower. They could then remove us from their list of providers, request refunds of their perceived overpayments, and/or reduce their coverage, making it less likely that we can serve the community well.

We realize that these are very complicated matters, but we do hope that this information will help you in your deliberations. If we can ever be of additional service to you, please feel free to contact us.

Thank you for your time and attention in reviewing our concerns.

Sincerely,

Gregory M. Hilliker
Managing Director

Flint Medical Supply
COMFORTCARE
G-5219 Corunna Rd. • Flint, MI 48504
313-733-6250

July 20, 1987

Jill Laitur
c/o Donald Riegle
352 South Saginaw Suite 910
Flint, Michigan 48502

Dear Ms. Laitur

I recently received a letter from Senator Riegle regarding the hearing he held in Flint on Health Care and the uninsured and underinsured. I greatly appreciated being invited to this hearing, however, prior commitments and after being out of the office for seventeen days I received the notice the day of the hearing, thus I was unable to attend.

Our industry continues to face shrinking profits due to the uninsured and underinsured. How long can private business be expected to provide services free? We are faced with the issue of humanity and staying in business. In addition, our reimbursement from Medicare continues to decrease as our administrative cost to process a claim escalate rapidly. Steps have been taken such as prompt payment with interest being paid on clean claims over thirty days, but there is no interest on claims that are rejected or unpaid and sent to review where payment is then made or even to fair hearing and payment is made. This process from the provider usually takes place with the documentation we submitted with our original claim. If carriers were penalized with interest for any claim paid with the documentation submitted from the original claim even through hearing was where payment was approved. Then carriers would use greater care in processing our claims.

When faced with all the claims processing regulations the uninsured and underinsured as of even greater concern.

In the future I would appreciate being contact of hearing in our area.

Sincerely

Jane E. Foust
Reimbursement Coordinator
Flint Medical
Perry Comfort Care

JEF/mm

Clyde Gardner

1375 Lathrup Street Saginaw, Michigan 48603

June 17, 1987

Hon. D onald W. Riegle,
U.S. Senate
105 Dirkson Bldg.
Washington, D.C. 20510

Dear Senator Riegle:

I would like to attend the Public Hearing on the Comprehensive Health Care Bill for Seniors. Since I cannot be there, I am sending tne attached. Perhaps you could have one of your staff present it for me in my absence.

Please accept my good wishes for the accomplishment of a final bill, which will adequately fill this serious need.

Sincerely,

Clyde Gardner

Encl.

Original to Washington Office

D I S C U S S I O N:

CATASTROPHIC HEALTH CARE BILL

Two issues are essential to make the project effective in filling its purpose:

1. How broad will the coverage be?
2. How will it be adequately funded?

(1) COVERAGE

The coverage should include all areas of CATASTROPHIC expense, ranging from the severe hospital and related costs through skilled nursing care to custodial care for victims of Alzheimer's Disease or other severe illnesses requiring several years of custodial care.

(2) FUNDING

There is currently a large loophole in the tax-collecting procedures, which, if closed, could provide, I believe, sufficient funds. This loophole is the non-collection of taxes on indirect income commonly called "fringe benefits". This would also correct a serious injustice which currently exists. Consider the following:

(a) The amount of tax dollars escaping is large. General Motors is reported to be paying more for medical fringe benefits than it does for steel.

(b) Looking at "justice" or "fairness", consider the cases of Mr. "A", a recipient of Medical fringe benefits, which pays for his BCBS insurance, his doctor bills, his prescriptions, his dental expenses, his eye glasses and his hearing aids. On the other hand, Mr. "B", who has no fringe benefits, has to pay for all of these out-of-pocket from after-tax money. To add insult to injury, Mr. "B" also pays for Mr. "A"' s medical expenses when he purchases a product or service from the employer of Mr. "A". In other words, Mr. "B" pays for the medical expenses of both himself and those of Mr. "A". I ask you, is this JUSTICE? This can and should be corrected, while simultaneously funding the CATASTROPHIC HELATH CARE PROGRAM.

Senator Riegle, I feel sure that you can see the merit of this proposal. Your office is in the Dirksen Building. I wonder what Everett Dirksen would do. I believe he would put justice and the value of the funding ahead of other considerations. Being a Statesman at times like this can open your door to a status level on the same plane with Senator Dirksen.

Original Design by Kotka

Genesee Valley Indian Association

124 W. FIRST STREET • FLINT, MICHIGAN 48502 • (313) 239-6621

June 17, 1987

Jill Laitur
Sabuco Building, Suite 910
352 South Saginaw Street
Flint, Michigan 48502

Dear Ms. Laitur:

I would like to testify at the Senate hearing on health care issues on Monday, June 22nd. I have two (2) issues to discuss:

1) The termination of ADC coverage for women who enter Substance Abuse Residential Treatment Programs. Women who are on ADC are virtually denied the opportunity to enter a residential treatment facility, because their ADC coverage automatically stops once they have entered treatment. They are unable to pay their rent and often find themselves faced with eviction or insurmountable financial problems. These problems prey upon them when they are in treatment, and have a serious affect on their efforts to better themselves.

   Under the current system, it seems that women are being punished for trying to improve their lives and the lives of their children.

   I am not suggesting that ADC continue full coverage for these women while they are in treatment. However, I am suggesting that perhaps ADC could maintain coverage of rent and utilities. This would lift a prohibitive financial burden from these women and allow them to concentrate on their alcohol/drug problems while they are in treatment.

2) The failure of Indian Health Services to meet the health needs of Indians in Michigan. For the past several years Indian Health Services has experienced a decrease in funding. As a result, in a growing number of cases Indians are being told to go back to their home reservations to get the help they need and that they cannot be served by Michigan Indian Health Services (MIHS) unless they are from a tribe idigenous to Michigan. Over 65% of Michigan's 61,714 Indians are not from Michigan Indian tribes. While being

UNITED WAY AGENCY

Genesee Valley Indian Association

refused by MIHS, these same Indians are often told by Department of Social Services to get the help they need from MIHS!

Transportation costs to return to their home reservations are often beyond their financial means.

If you have any questions about these vital health issues, or if you have suggestions, please contact me at 313/239-6621.

Sincerely,

Jennifer A. Smith

Jennifer A. Smith
Executive Director

|nj

HAMILTON AVE. FAMILY HEALTH CENTER
752 East Hamilton Ave./ Flint, Michigan 48505

July 7, 1987

JUL 8 1987

Honorable Donald W. Riegle, Jr.
U.S. Senator
Sabuco Building, Suite 910
3525 South Saginaw Street
Flint, MI 48502

Dear Senator Riegle,

The purpose of this letter is to share with you our mutual concern for the health and welfare of Flint area residents (Genesee County).

With further layoffs of General Motors employees inevitable, it is obvious that the need for quality health services will greatly increase.

At Hamilton Ave. Family Health Center (HAFHC) we often run into grave, heartbreaking situations that our indigent patients face.

For example, one gentleman had to be referred to Wayne State University Hospital in Detroit because he earned too much money for Medicaid. Unfortunately, he did not earn enough to pay for the substantial medical bill that he received. A biopsy was needed and he was willing to make payments. However, all the physicians that we referred him to wanted too much in an advance payment. We finally, after many arduous attempts, located help for him 65 miles from Flint.

To illustrate the gravity of the situation one patient said to me, "Well I guess I'll just have to die with this thing (disease)."

It is far from uncommon for us to have Medicaid and Medicare patients who need a specialist and can't find one who will accept their insurance. And many Medicaid and Medicare patients feel that they are treated with contempt by most medical and dental providers.

We at HAFHC are dedicated to the principle that all people have a right to quality health care services with dignity. We have a government funded sliding-fee-discount program for indigent patients. Our indigent population generally qualify for 60% to 100% discounts on their medical, dental, and lab/x-ray services.

We have reached our saturation point however, in terms of space and the volume of patients we serve at this facility.

Continued government support is essential for the efficient operation and expansion of our Health Center.

We join you in your effort to create greater access to quality health care for those in need. Your continued support is critical.

Sincerely,

Lutullus Penton
Director of Marketing/Social Services

LSP/bkm

HURLEY MEDICAL CENTER ONE HURLEY PLAZA, FLINT, MICHIGAN 48502 PHONE (313) 257-9000

July 2, 1987

Senator Donald W. Riegle, Jr.
United States Senate
Senate Office Building
Washington, D.C. 20510

Dear Senator Riegle:

I thank you very much for inviting me to your senate hearing on health care issues on Monday, June 22. Unfortunately your letter, although dated June 12, 1987, did not arrive in my office until June 25. However, I will take this opportunity to share with you some of my views.

I too am very concerned about the problems with the uninsured and underinsured. As the program director for Internal Medicine Resident Education at Hurley Medical Center in Flint, a large portion of our population in the clinics and in the hospital are this type of patient. I see a significant issue in regards to the uninsured and underinsured in term of accessing the health care system and being able to come into the clinics to be seen as an outpatient for follow-up; in addition, in fact, when these patients are admitted to a hospital with any given diagnosis they generally are much more ill then the diagnosis would imply in terms of either a malnourished or undernourished patient, whether young or old, etc.

It is very clear that many of these patients have no ability to access ancillary resources which might either have avoided their hospital stay, shortened it, or altered it in some fashion. They are not able to easily access dietary services, social services, laboratory services as an outpatient, many have difficulties commuting to and from their home to the clinic, and many feel that they can't afford the clinic and they are not going to come even though collections in the clinic are so low that most of these patients are not charged for their visits. Furthermore, due to the budgetary cuts in the state of Michigan including the recent Medicaid cut, this hospital has suffered a 3.8 million dollar reduction in its Medicaid budget further limiting the amount of services that can be provided to this population. The impact of this budgetary cut has affected employees, the number of employees, there have been layoffs and there will be loss of positions through attrition, etc. The ability to serve these patients, thus, has been significantly hampered. I should note to you that much of this has a relationship not only to Doctors

fees but, in addition, I think thats the smallest part of the problem. I think there are physicians, especially in our system, resident physicians and a full time hospital clinic director that can provide care to that kind of population, but patients are unable to pay for medications, they are unable to access radiologic, laboratory services, and many times they feel terribly depressed or desperate so that they just don't come into the clinic for follow-up.

Its very clear, at least to me, that this patient population needs greater access not only to physician services but to those health care services which have the potential to improve their overall health and nutrition. I don't believe this is happening currently.

Additionally, I think the malpractice climate generally in the country and particularly in the state of Michigan has gone to great lengths to further limit the care of this unfortunate group of people. Because of the malpractice issues that surround these kinds of patients, if not in actuality, in the minds of health care providers, it is very difficult to access the needs for specialty care for this patient population. People are very much concerned that this population has a high alcohol and drug utilization rate in addition to being generally less healthy than other middle class Americans, many of the physicians don't care to get involved because their much concerned that they will be sued in a later malpractice case, independent of whether or not any has been committed. I think this is an issue of the highest order and is burning physicians; and I do believe that because of this, patients, not only the underinsured and uninsured, but all patients are recieving a different type of health care in this kind of climate. Furthermore, in the city of Flint, as you are well aware, the unemployment is still significant and is increasing due to the difficulties with GM and its associated industries. It is clear that in order to up-grade the health of the population in this city that alterations in the economic system and economic opportunities have to come about for this group of people. Number two, the state and federal government have to take a larger role and more effective role in providing health care services and activities and ancillary activities to this group of patients for their well being. Additionally, serious issues regarding malpractice, the malpractice laws and climate have to be addressed before any serious increase in the accessability to some speciality health care can be assured for this group of individuals.

In any event, should your committee again return to Flint I would certainly like to provide testimony as a person with significant first hand experience with at least some of these issues

both from a directors stand point in addition to involvement with the education of developing physicians and medical students. Thank you very much for inviting me to testify, I am sorry that your letter did not arrive at such a time that would allow me to have testified. Again thank you very much for considering my opinions. If you wish any further information I would be glad to discuss these or any points in greater detail. I remain,

Sincerely yours,

Robert W Rosenbaum MD.

Robert W. Rosenbaum, M.D.
Associate Professor of Medicine
Michigan State University
Program Director,
Hurley Medical Center
Internal Medicine Resident
Education program

RR:jjm
IMS2:LET/RIEGLE

HURLEY MEDICAL CENTER ONE HURLEY PLAZA, FLINT, MICHIGAN 48502 PHONE (313) 257-9000

July 24, 1987

Sen. Donald W. Riegle, Jr.
C/O Joan Huffer
105 Dirkson Senate Office Bldg.
Washington, D.C. 20510

Dear Sir:

My private practice in Flint, Michigan was devoted to surgical oncology for over thirty years. I am now the medical director of the Community Cancer Center at Hurley Medical Center.

I applaud your efforts to help those without access to adequate health care. It is evident that present increasing restrictions on reimbursement and mounting costs to physicians and hospitals cannot allow them to bear the burden of care for this group.

Data to date has not convinced me that this country cannot afford adequate health care for its citizens. You have no doubt collected great numbers of examples representing the problem. An example of the underinsured that I find disappointing is when the wage earner of a family became ill and the health insurance carried was dependent upon continuing work. I have seen cancer patients forego important treatment so as to work to keep the health insurance for their children.

I believe health care is one of the rights owed to the citizen. It is a privilege for physicians and other health care providers to have been provided the skill to care for ill people. It is also necessary that the health care provider be adequately reimbursed and have proper moral, ethical, and legal protection to carry out the task.

Sincerely,

Max Dodds

Max E. Dodds, M.D.
Director
Community Cancer Center

MED/mfy

HURLEY MEDICAL CENTER ONE HURLEY PLAZA, FLINT MICHIGAN 48502 PHONE (313) 257-9000

July 31, 1987

Jon Hupper
105 Dirson Center Office Building
Washington, DC 20510

RE: Problems of uninsured people in Flint, MI

Dear Dr. Hupper:

Under separate cover I am sending a letter to Senator Reigle containing some of my fellings regarding this problem. I will restate a few of the issues as I understand them and hope that they are helpful to the Senator.

Access to center in-patient health care for the uninsured and under-insured in Flint is not per say a problem in the sense that Hurley Medical Center, being a city hospital admits all patients, based on medical need, as opposed to financial ability. However, despite the fact, it has become very difficult in the last two to three years to find physicians in the community who are willing to accept these patients on their primary general medicine service. In order to supply appropriate primary care, the hospital has had to employee more full time physicians and some speciality physicians to fill its needs within the hospital. Unfortunately, the same is not entirely true for patients needing some future speciality care in the hospital. Many of these sub-specialists either will not or are not able to see these patients even in the hospital, unless, in fact, there is a medical emergency and even under those circumstances, there has been situations where patients have not been seen, presumably due to the fact they were under or uninsured. It should be noted that many physicians view this particular group of patients or a sicker group of patients much more unable to take care of themselves, or are living in a lower social economic strata with less effective nutrition, greater incidence of drug and alcohol related problems.

and a higher risk for an adverse outcome of their illness and feel that these patients have a higher rate of law suit than private patients do. Whether or not that fact is absolutely correct is debatable. however, that's how the private physicians perceive that particular situation. Their access to subspecialty and primary health care as an inpatient are diminished or rapidly diminishing. This hospital does have a sufficient clinic structure that does allow patients to be seen in the out-patient setting, however, many of the previously mentioned factors continue to play a role in ease of assessibility. Many of the sub-speciality physicians refuse to see the under-insured or the uninsured patient in the out-patient setting.

1) Although the bulk of our clinic patients are seen by residents under the direct supervision of a full time out-patient clinic director, reimbursment for this position is tenure. The hospital absorbs the cost of procedures to get appropriate attending level directorship of the out-patient clinic.

2) Follow-up care is affected by the fact that the patient is either unable to come to the clinic due to the lack of either their physical ability, their ability to gain transportation to and from the hospital, or their ability to follow-up with medical regiments and obtain needed medicine and service.

The list of problems are long and growing. These are but a few. Hopefully, this information will be helpful to Senator Reigle.

Sincerely yours,

R. W. Rosenbaum, M.D.
Director of Internal Medicine
Education Department

RWR:gjw
d2:LET/Hupper

Honorable Donald Reigle: June 22 1987

My name is Floyd Laetz and I'm here to speak on behalf of the FLINT AREA CHAPTER # 304 of the AMERICAN ASSOCIATION of RETIRED PERSONS to speak on CATASTROPHIC INSURANCE. We the members of Chapter 304 are in favor of CATASTROPHIC INSURANCE but we are opposed to FINANCING by counting MEDICARE BENEFITS as income when calculating your income tax. Even thou a lot of the SENIORS would not have to pay this additional amount, taxing MEDICARE benefits should not be done.

Other ways can be found to pay for CATAST-ROPHIC INSURANCE I'M sure, such as raising the FEDERAL income tax. SURE IT NEEDS FUNDING but lets not consider taxing BENEFITS as an income. THIS is not an earnings, so therefore it SHOULD NOT EVEN BE CONSIDERED. WHO WANTS TO BE IN HOSPITALS AND THE BENEFITS YOU GET BE CONSIDERED AS IF YOU ARE WORKING ? I'm sure I wouldn't want it that way. Yes SENATOR REIGLE, we need CATASTROPHIC INSURANCE and anything you can do to help us, would be greatly appreicated by the SENIORS of this GREAT NATION. I want to thank you for allowing this time and I hope that you will oppose **FINANCING** by considering MEDICARE BENEFITS AS INCOME

AS A CLOSING REMARK, THE SENIORS PAY OUT OF EACH S.S. CHECK A PAYMENT TO ALREADY PAY FOR THESE MEDICARE BENEFITS, THERE A VERY GOOD REASON WHY MEDICARE BENEFITS SHOULD NOT BE TAXED.

THANK YOU FOR ALLOWING ME TO SPEAK OUT ON THIS ISSUE

FLOYD G. LAETZ

Mr. Floyd G. Laetz
3741 Whittier Av.
Flint, MI 48506

Michael Vizena, Executive Director
Genesee County Community
mental health services
CHILD AND ADOLESCENT SERVICES Gail Stimson, A.C.S.W. Program Director
1102 Mackin Road Flint, Michigan 48503 Telephone (313) 257-3676

June 22, 1987

The Honorable Donald W. Riegle, Jr.
910 Sabuco Building
352 S. Saginaw Street
Flint, Michigan 48502

Re: Uninsured and Underinsured Health Coverage

Dear Senator Riegle:

As you are aware, numerous residents of Genesee County are faced with termination of their insurance benefits. This is a result of the work-force reduction in the automobile industry and related businesses. Our county stands to be disproportionately affected and the percentage of families without adequate health insurance will increase.

In response to your request for comments and views on health care for the uninsured and underinsured, I wish to draw your attention to several facets of the issue.

> Often people do not consider psychiatric services benefits under "health care" until they are in a position of need.
>
> There is a lack of coverage for those families who fall between qualifying for Medicaid, do not have health insurance, and do not have enough financial resources.

One of the expected results of our increasingly high unemployment is the psychological impact on families undergoing major employment changes which can produce intense stress. The children are particularly venerable to stress within these families. This coupled with a significant portion of youth whose employment picture remains bleak will continue to impact on the health care system.

Referrals for mental health services rise and additional intervention needs are being identified. Families who may have sought help privately will no longer have that option without insurance. This additional demand for

services will be on a mental health system which is already strained. For example, Child and Adolescent Services has an outpatient waiting list of almost 200 families requesting services.

Adequate health insurance is necessary for families, especially those at high risk. Numerous studies point to the role of stress on physical and psychological symptoms.

Health care legislation aimed at aiding these high risk families would certainly be in order, especially in Genesee County, where the number of individuals/families with inadequate health coverage is growing rapidly.

Sincerely,

Gail H. Stimson

Gail Stimson, ACSW
Program Director

GS:bjm

pc: Michael Vizena

Richard E. (Dick) Petticrew
Monroe County Board of Commissioners
Representing District 1

354 Saline Street, Petersburg, Michigan 49270
Telephone: Business-(313) 243-7016 / Home-(313) 279-1833

August 5, 1987

Donald W. Riegle Jr.
U.S. Senator
253 Russell Senate Office Bldg.
Washington, D.C. 20510

Dear Senator Riegle:

I would like to personally apologize for not being able to testify before your committee on Health Care Issues, and also not having my imput to you by August 4, 1987. My work schedule has been quite heavy.

However, I would like to give you some of my thoughts on catastrophic and long-term illnesses. As you are aware many individuals face the above who are uninsured. I strongly urge your committee to diligently word toward a goal of protecting these individuals.

In my years of public office, I have witnessed many of this type of situations. Again, I urge you to support a program that will guarantee all of our citizens proper insurance coverage.

Sincerely,

Richard E. Petticrew
Chairman

REP/JRE/tl

Children... a good place to start.

June 26, 1987

Honorable Donald W. Riegle, Jr.
United States Senate
Washington, D.C. 20510

Dear Senator Riegle:

I am sorry that I was unable to attend the Senate hearing on health care issues which you held in Flint on June 22. I was out of town on the 18th through the 21st and received your letter of invitation to attend at 11:30 on the morning of June 22. I certainly would have appreciated the opportunity to attend the meeting.

I do have some issues that address the problems of health care to medically indigent and underinsured children.

It is a known and proven fact that more and more children live in impoverished homes with either unemployed parents or single parents who have access to few resources and who frequently have minimal health care coverage or none at all. There is an increasing population of underinsured children because their parents work in minimum wage jobs with no health insurance or are part-time employees who do not qualify for health insurance and other fringe benefits. There are many working parents who have part-time jobs and neither parent has adequate health insurance. These children fall between the cracks and are not even covered under Medicaid because of the parent's efforts to be self sufficient.

I believe there are some basic principals which relate to the delivery of health care that must be considered. First, it seems apparent that basic health care should be a right and not a privilege for our children, both while they are being carried in-utero and after birth, at least for the first several years of life. This basic health care should include preventive services of proven value, illness-related care in both outpatient and inpatient settings, and catastrophic coverage. In addition, Medicaid must be expanded and probably will need to be Federalized to provide this type of basic insurance to all in need. Variations between states is not just and cannot be justified.

Mott Children's Health Center • 806 Tuuri Place • Flint, Michigan 48503 • (313) 767-5750

Another concern is the wide variation in provider compensation that is provided by various third-party payers. Levels of coverage provided by various insurance systems also varies. As a minimum, the fetus, the newborn, and the infant must be covered with some type of minimum health insurance that provides the above coverage. The health insurance companies must be regulated to assure that minimum standards are met. This would include prenatal care, well-baby care including immunizations, other preventive services for children, and care of acute and chronic illness in both inpatient and outpatient settings.

The future of our society rests with our children. It appears that we are rapidly following a road to a two-tiered society, those who have and those who have not. The potential for significant social and political disturbances appears obvious if this should continue. The "court of last resort" is the Federal government and I think that the time has long passed for these measures to be developed and implemented.

Again, I apologize for not attending the public forum. I hope that these thoughts will be helpful to you.

Keep up the good work.

Sincerely,

John W. Tauscher, M.D.
Vice President of Health Affairs
Chairman, Dept. of Pediatrics
Hurley Medical Center

JWT/db

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July 21, 1987

Senator Donald W. Riegle Jr.
SD 105
Washington, D.C. 20510

Dear Senator:

My name is Susan Lapham, I am the Marketing Representative and Field supervisor for Professional Home Health Care in Brighton. We are a full service, 24 hour a day, 7 day a week, Home Health Care Company.

I have attended your forum in Warren and Flint, listening to speakers on both sides. I am neither a business executive nor do I have a chronic illness. Which means I can't speak of personal Health and financial problems or can I quote financial and medical statistics. But I can talk about the client who if it weren't for Home Health Care would not get a hot meal, a bath, or general home cleaning. Or the young married woman whose husband has a good job and insurance but they never expected medical bills for their new baby to not be completely covered by insurance when they found that he had to be suctioned daily, and no one would help them.

We as all other Home Health Care agencies are called daily by a elderly man or woman desperately needing help. But their only income is social security which financially cannot allow them to hire help, and not always are they eligible for D.S.S.

Senator Reigle your idea for Health Reform is something I agree with, and while talking to many elderly about it have agreed. My hopes are that there will soon be relief tor people who are in need of help, getting it.

Sincerely,

Susan L. Lapham
Marketing Representative
Field Supervisor

Enclosure

SL/bm

STATE OF MICHIGAN

JAMES J. BLANCHARD, Governor

DEPARTMENT OF PUBLIC HEALTH

3500 N. LOGAN

P.O. BOX 30035, LANSING, MICHIGAN 48909

GLORIA R. SMITH, Ph.D., M.P.H., F.A.A.N., Director

June 26, 1987

The Honorable Donald W. Riegle, Jr.
United States Senator
Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Riegle:

Your recent invitation to participate in your public hearing on "Health Care for the Uninsured" is very much appreciated. Although unable to attend, I wish to inform you of efforts here in Michigan to address this issue.

In 1985, the Michigan Department of Public Health in concert with its Public Health Advisory Council reviewed the status of the access problem in Michigan, discussed the activities that had been initiated to date, and set forth a number of recommendations for future activity. Issuance of that document, "A Report on the Issue of Access to Care in Michigan," contributed to the development of two major statewide initiatives regarding access to care. The first, implemented earlier this year, is the Health Care Access Project supported by funds from the Robert Wood Johnson Foundation. A key feature of this project is the "One-Third Share Plan." The "One-Third Share Plan" is designed to provide an affordable health benefit to persons who leave General Assistance or AFDC due to employment, whose jobs provide no health insurance and any other coverage (such as a Medicaid extension) is exhausted. Under this plan, the cost of care, in some kind of a managed care system, is to be shared equally in one-third shares by the employee, the employer and the state. In other words, it is a subsidized health insurance plan which will be made available to persons who work their way off of welfare and to the employers who hire them. Detailed information on this effort was provided Monday by Vernon K. Smith, Ph.D., Director; Bureau of Program Policy; Medical Services Administration; Michigan Department of Social Services; Lansing, Michigan 48909.

The second, complementary initiative is designed to facilitate a broader look at the issue of health care for the uninsured and underinsured. This initiative results from the recommendations of the Governor's Human Services Cabinet which I chair. Cabinet membership includes the Directors of the Departments of Public Health, Social Services, Mental Health, Management and Budget, Education, Civil Rights, and the Offices of Services to the Aging and Substance Abuse Services.

The Cabinet has recommended that a two-year state health access project be initiated to involve not only the Human Services Cabinet and the participants of the Robert Wood Johnson Foundation proposal, but also business, labor, academia, the Legislature, and private foundations. The Governor is currently finalizing this proposal and I expect that the details of the project, along with the membership of the task force, will be announced shortly.

It is clear, however, that the mandate of the project will be not only to define the scope of the access problem but to propose workable solutions that recognize public funding limitations and maximize the public/private partnership.

The Governor's leadership, in cooperation with the Legislature and the private sector, should be the impetus for developing creative, fiscally responsible strategies that will extend the range and comprehensiveness of health care protection for the citizens of this state. The Governor's Office will be providing you with specific details once the project is underway.

Critical to our success is the development of complementary initiatives which extend and support activities now being taken in this area by states such as Michigan. Proposals such as those embodied in Senate Bill 1265 sponsored by Senator Kennedy and Senate Bill 177 sponsored by yourself, if enacted, would significantly enhance individual state efforts. Additionally, such actions would do much to "level the playing field" among the states by reducing the disparities between states which aggressively pursue remedies to this problem and those which do not.

In closing, let me say that I feel strongly that we need to work together in a complementary fashion to look at how best to weave a federal/state safety net, one which allows for appropriate access to needed care and avoids the impoverishment of families or individuals because of medical need. I fully support your efforts and will be pleased to work with you on this issue. Please feel free to contact me as you move forward. We will provide as much assistance as is possible.

Sincerely,

Gloria R. Smith
State Health Director

cc: Human Services Cabinet Members

RICHARD L. RAPPORT, M.D.
PRACTICE LIMITED TO THORACIC SURGERY
AND DISEASES OF THE THYROID
2710 W. COURT STREET, SUITE 9
FLINT, MICHIGAN 48503
TELEPHONE 767-5220

July 27, 1987

Ms. Joan Huffer
105 Dirksen Senate Office Building
Washington, D. C. 20510

Dear Ms. Huffer:

This is in response to Senator Riegle's request to submit written testimony concerning health insurance for the uninsured and underinsured.

As you probably know the American Medical Association has been addressing this problem over a period of years. I enclose two reports from the Council on Medical Service which you may find pertinent.

Other informational reports are available - especially Board of Trustees report MM(A-86). I am not able to find this in my files but suggest you request a copy of this (and other material) from the AMA or the Michigan State Medical Society. Should you have any difficulty do not hesitate to ask for my help.

Sincerely yours,

Richard L. Rapport

Richard L. Rapport, M. D.

RLR/ph

REPORT OF THE COUNCIL ON MEDICAL SERVICE—REPORT: F (A-87)

Subject: Financing Long-Term Care.
Presented by: Robert D. Burnett, M.D., Chairman.
Referred to: Reference Committee A (H. William Porterfield, M.D., Chairman).

INTRODUCTION

There is increasing concern over how best to finance the growing expenses of long-term care. This concern has been accentuated by the fact that persons over age 65 represent the fastest growing segment of the U.S. population, and that this group is at the highest risk of incurring chronic illness or disability. The present report provides: a) pertinent background information on this issue, b) a description of the types of services which should be considered for coverage in a "long-term care" financing program, and c) an overview of private sector approaches for financing long-term care under consideration or trial. This report is presented for the information of the House. Subsequent reports will address relevant policy issues.[1]

BACKGROUND

The elderly population in the U.S. (65 years of age and over) is expected to more than double from 1980 to 2030; from 25 million persons or 9.9% of the total U.S. population, to 55 million, or 18.3% of the U.S. population. In addition, the age composition of the over-65 group itself is changing. Between 1980 and 1990, it is projected that the number of elderly individuals 65–74 years of age will increase by 13.8%, those age 75–84 years of age by 26.6%, and those 85 years and over by 20.1%.

This unprecedented growth in the older population—particularly the 75-plus age group—will have a major impact on the nation's health care system. It is well documented that while elderly individuals today are generally healthier than elderly individuals of preceding generations, persons age 65 years and over utilize a substantially greater proportion of health care services than do the rest of the population. In adopting Board of Trustees Report MM at the 1986 Annual Meeting, the House has already recommended a fiscally and actuarially sound proposal for financing the growing acute health care needs of the elderly. Another critical policy issue affecting the care of both the elderly and a certain portion of the under-65 population in the coming years, however, will be an increased need for the financing of long-term care services.

As indicated in Board of Trustees Report W (I-84), "Long-Term Care for the Chronically Disabled," the term "long-term care" has traditionally been used to connote a broad range of both medical and supportive/custodial services for individuals who have lost some capacity for self-care due to a chronic illness or condition, and who are expected to need care for an extended period of time. Long-term care services are often concerned with minimizing the effects of one or more diseases and with delaying deterioration of the person's functional capabilities rather than with curative or restorative goals.

While it has been estimated that approximately one-third of the long-term care population is under age 65, the need for long-term care strongly increases with age. In 1977, 89% of nursing home residents were over 65 years of age. According to the American Health Care Association (AHCA), an organization representing proprietary and nonprofit nursing homes, nursing home utilization also increases with age within the elderly population, from 2% among persons age 65–74 years to 23% of those 85 years and older. Similarly, it has been estimated that the percentage of the elderly needing personal care (i.e., assistance with eating, toileting, mobility, bathing, dressing) increases from 2.6% in the 65-74 year-old group to 31.6% of those 85 years of age and older.

Given the projected growth of the elderly population and current patterns in utilization of long-term care services, major increases in the demand for such services are anticipated. This fact has intensified pressure for the development of adequate mechanisms to finance these services for persons of all ages, since the expense of long-term care is becoming one of the leading causes of impoverishment.

Most of this nation's expenditures for long-term care are for nursing home or other institutional care. These expenditures are almost equally divided between public and private sources, with Medicaid picking up most of the former. Medicaid accounts for about 48% of the nation's long-term institutional care expenditures. This expenditure represents more than one-third of total Medicaid payments, and in

[1] Past House Action: A-86:91-96, 185-200; A-84:97-105.

some states accounts for almost two-thirds of the state's Medicaid budget. Private, out-of-pocket expenditures account for 48% of long-term institutional care expenditures. Private insurance payments account for about 1% of total national expenditures for long-term institutional care. Medicare, which only covers up to 100 days of post-hospital care in a "skilled nursing facility," accounts for only 2% of these expenditures.

A significant portion of Medicaid spending for long-term institutional care is on behalf of individuals who have "spent down" to eligibility. It is estimated that half of all current Medicaid nursing home residents did not initially qualify for Medicaid, but spent down their income and assets to Medicaid levels while institutionalized.

DESCRIPTION OF LONG-TERM CARE SERVICES

The Council believes it is important, for purposes of financing mechanisms, to distinguish between such health-oriented services as skilled nursing care and physical, occupational and other rehabilitative therapies on the one hand, and the type of personal, supportive and custodial services needed on an ongoing basis by persons who have lost some capability for self-care on the other. Either or both types of services may be required on a continuing basis by "long-term patients."

The former group of services are those normally covered under traditional health insurance plans, and—when their duration is protracted—under the catastrophic expense portion of such plans. The latter category of services is the one for which private sector protection is largely lacking, and for which new approaches are needed in the Council's view. Within that context, the types of services which should be considered for coverage under long-term care financing mechanisms can be more specifically identified as follows:

Institutional care

—Personal care services to assist individuals with the basic activities of daily living and help prevent further deterioration in physical and mental capabilities, such as providing assistance with mobility, dressing, eating, bathing, grooming, and socialization.

—Congregate living services—e.g., meal preparation and service, housekeeping and room maintenance, etc.

Noninstitutional services adjudged by a health professional as needed to avoid more expensive institutional care [1]

—Personal care services as defined above.

—Homemaker services (e.g., food preparation, laundry, shopping and light housekeeping).

—Home delivered and/or congregate meals: nutritional meals for individuals who cannot prepare their own, either delivered to the home or provided in a communal location (e.g., senior center, church, school, etc).

—Specialized transportation to medical and other needed services for individuals with personal mobility limitation.

The Council recognizes that coverage for both health-oriented and personal/custodial services may be offered under the same financing mechanism or plan, and that both types of services may be needed simultaneously in the same care setting by a given individual. The Council believes, however, that coverage for only the personal/custodial category of health care expense should be available separately, to assure that only needed services are being provided.

PRIVATE SECTOR INITIATIVES

Given the increased pressures for the development of adequate mechanisms for financing long-term care, and the fiscal constraints being imposed on the public sector, the Council believes that private sector financing mechanisms will play an increasingly important role in addressing this issue in the future. Although private sector involvement in financing long-term care is currently minor, there is increasing evidence of activity and experimentation. While private sector mechanisms have received increased attention primarily within the context of the growing number of elderly requiring long-term care, some of these approaches are potentially applicable to the needs of young long-term patients as well.

---

[1] Some consistent method of determining need/entitlement to such noninstitutional services is needed to assure their most cost-effective use.

In general, private sector initiatives for financing long-term care can be grouped under four main categories: indemnity insurance plans, managed care approaches, cash accumulation plans, and family support. These initiatives are discussed below. Information on these initiatives was obtained through CMS discussions with representatives of the insurance industry and research organizations who are addressing this issue, and from a review of the literature.

Indemnity Insurance Plans.—About 75 insurance carriers are currently marketing or developing long-term care insurance products and an estimated 200,000 policies are in force. Most long-term care insurers are marketing individual indemnity policies to pay a fixed amount for each day of service in specified institutional settings and/or for specified levels of intensity. These policies typically provide coverage for two to four years of institutional skilled nursing care and for institutional intermediate and custodial care, but for a lesser amount of time and at a lesser rate than skilled nursing care. Definitions of the different levels of care vary among carriers, however, and the amount of payment is usually based on the type of facility providing the care rather than on the level of care provided. Home health care benefits are also provided under some of these policies, but these benefits are often limited to the services of a private duty nurse.

Although there are several identifiable common characteristics among these plans, a comparison of their premiums is not possible, given the wide variety of features and benefits which could influence the premiums charged. In general, however, premiums for individual long-term care insurance policies are usually structured by age groups and reflect increasing risk with age. The beginning age of issuance under these policies ranges from 50 to 65 years. Some policies set premiums at issue age and do not increase them subsequently for individual enrollees, while others increase premiums as enrollees grow older.

Long-term care insurers employ a variety of risk management techniques. Fairly common approaches include the use of waiting periods, prior hospitalization requirements, preexisting condition clauses, explicit exclusions, and health status screening questions. Few policies provide first-day coverage, but offer beneficiaries a choice among various waiting periods ranging from 20 to 100 days. Most policies also contain a three-day hospitalization requirement prior to covered confinement in a long-term care institution, with confinement being for the same illness or injury which required hospitalization, and beginning within a certain number of days (typically 30 days) after hospital discharge. Such prior hospitalization provisions are patterned after a similar Medicare requirement for coverage of skilled nursing facility care.

Preexisting condition exclusions or limitations are found in virtually all existing individual long-term care insurance policies. Most policies delay, or in fewer instances permanently exclude, benefits for services required as a result of an injury or illness diagnosed or treated at any time prior to the effective date of the policy. A few insurers, however, only apply this restriction to conditions treated within a specified time (e.g., six months) prior to plan enrollment. The delay before benefits are provided for expenses resulting from a preexisting condition ranges from 30 days to 12 months, depending on the policy.

In addition to exclusions or temporary limitations for preexisting conditions, policies also typically exclude coverage under specified circumstances or for selected illnesses. It is standard practice for long-term care policies to exclude coverage of expenses incurred outside the United States, resulting from war or intentional self-inflicted injury, and caused by mental disease and disorder. Some of the policies, however, only exclude coverage for mental disease and disorder if the problems are without "demonstrable organic disease."

Another risk management technique employed by long-term care insurers involves the use of health status screening questions. Prospective subscribers of long-term care policies are usually asked questions regarding their health status which are designed to screen out those who would be at high risk in regards to their use of benefits. The screening questions typically seek information regarding an applicant's record of prior institutionalization and specific illnesses. These questions vary among insurers in their level of detail and the previous time period which their responses must cover.

Two specific examples of long-term care indemnity insurance policies are those marketed by CNA Insurance Companies and the American Association of Retired Persons (AARP). In addition, Thomas E. Getzen, Ph.D., of Temple University has proposed a plan which combines long-term care insurance and a deferred annuity benefit. These plans are briefly described below.

CNA Insurance Companies' convalescent nursing care plan

CNA has provided a health insurance product indemnifying nursing facility confinement since 1974, and approximately 30,000 policies are currently in force. Claim payments resulting from these policies in the last five years have totalled $15.4 million.

Marketed primarily to individuals, CNA's Convalescent Nursing Care Plan provides a daily cash benefit of up to $80 for medically necessary convalescent care, defined as skilled, intermediate or custodial nursing care services furnished under the orders of a physician in a licensed skilled or intermediate care facility. Benefits are provided for a stay of up to 1,000 consecutive days for issue ages 60–79 and for up to 365 days for issue ages 80–84, with a lifetime maximum benefit of up 1,500 days. Unless otherwise assigned, benefits are paid directly to the subscriber.

Benefits can begin after a waiting period of 15, 30 or 90 days of nursing facility confinement. To receive benefits, confinement must commence within 30 days of discharge from a hospital following a stay of at least three consecutive days, and be for the same injury or illness which necessitated hospitalization.

Potential subscribers to CNA's plan are required to provide information regarding specific illnesses they have had and any confinements in a hospital, nursing home, or convalescent care facility they may have experienced within the previous five years. This information is used by CNA primarily to assign subscribers to a health risk category for premium purposes. Approximately 15% of applicants are denied coverage entirely based on this medical history.

A preexisting condition clause in CNA's plan restricts benefits for conditions for which subscribers received medical advice or treatment in the six months preceding the effective date of their policy. Most such conditions, however, are covered if confinement begins at least 90 days after the policy's effective date. Explicitly excluded from coverage are expenses for confinement due to injury or illness for which benefits are payable under a Workers' Compensation or Occupational Disease Act or Law, resulting from war, or due to mental, psychoneurotic, or personality disorders without demonstrable organic disease. The policy does state that expenses for mental conditions of an organic origin, such as mental abnormalities resulting from an accident or Alzheimer's Disease, are covered.

CNA's long-term care policy is guaranteed renewable; that is, a policy will not be cancelled except for lapsed premium payment. CNA does reserve the right, however, to change a subscriber's premium if the subscriber is given 30 days prior written notice and the premium rate for everyone in the subscriber's policy rating group in that state is changed. With this exception, premiums are set at the time the policy is issued and are not increased for individuals thereafter. Age of eligibility for the plan is 60. The policy rating group to which a subscriber is assigned is dependent upon the waiting period and level of benefit selected, and the subscriber's age and health status.

In the near future, CNA will also offer enrollees in its long-term care plan an option providing coverage for home health care. According to a representative of CNA, the company anticipates that features of this option will include a 120-day waiting period, a prior hospital or nursing home confinement requirement, and a life-time maximum benefit of two years coverage. In addition, it is anticipated that, rather than an indemnity benefit, this option will be provided as a service benefit, with the plan paying customary charges for medically necessary home health care services up to a certain percentage of the maximum nursing home benefit payable.

AARP/Prudential's long-term care policy

AARP began pilot-testing a long-term care policy, underwritten by Prudential Insurance Company of America, in late 1985. When the plan was test marketed to a random sample of AARP members in six states, 1,200 purchased coverage, a response rate of only about one-half of one percent.

The test product offered subscribers nursing home benefits of $40 per day (regardless of the level of care required) following a 20-day waiting period and a three-day hospital stay, with a lifetime maximum of 1,095 days or 3 years. The policy also provided payment for home health personal and skilled care visits at $20 and $25 per visit after the first 20 visits, up to a maximum of 365 visits. Premiums ranged from $180 to $1140 per year, depending on the age of the purchaser, with the premium set at the time of purchase (minimum enrollment age of 50). The plan included a six-month delay of coverage for preexisting conditions. Potential subscribers were required to complete a medical questionnaire but only 3% were declined coverage for medical reasons.

In surveying its members in the six states who had received enrollment packages, AARP found that two-thirds of the nonpurchasers believed that they did not need

this type of coverage. More than one-third of the nonbuyers erroneously believed that they were already covered for long-term care through Medicare and/or Medigap insurance.

Based on the results of its test marketing, AARP has recently revised its plan. The hospitalization requirement has been deleted, the duration of the nursing home benefit has been extended to four years, and the waiting period has been increased to 90 days/visits. In lieu of the prior hospitalization requirement, AARP/Prudential's Patient Assessment Unit—a case management process—will be used to identify and oversee the level of care needed. This revised long-term care policy is again being test marketed in six states.

Getzen's proposed long-life insurance plan

A plan which combines long-term care insurance and a deferred annuity has been proposed by Thomas E. Getzen, Ph.D., of Temple University. Getzen's proposal, "Long-life Insurance Plan," would enable a single person or a couple to participate in the plan by paying its premium either in a lump sum using a portion of their accumulated pension benefits from employment, and/or in monthly payments for life. In return, participants would receive indemnity payments for institutionalization in any level of facility that provides continuous nursing care such as a hospital, skilled nursing facility or state licensed nursing home after their first year of enrollment and 45 days of confinement. In addition, after age 75, participants would receive annuity payments regardless of their health status or living situation. These annuity payments would be made in addition to any indemnity payments being made for nursing care.

As an example of the premium costs and benefits of this proposal, Getzen anticipates that for a lump sum payment of $23,008 or a monthly payment of $246, a single male age 60 could receive indemnity payments of $66 per day for nursing home confinement and annuity payments of $20,000 per year after age 75.

In discussions held with the Council, Getzen indicated that this proposal allows the provision of benefits which are large relative to premiums by balancing risks and reducing adverse selection. Participants at high risk who are likely to utilize the indemnity benefit for institutionalization are also more likely to suffer early mortality, reducing the plan's annuity payments. On the other hand, participants who are attracted by the annuity payments are less likely to be institutionalized. In addition to limited adverse selection due to the reduction in the number of annuitants through mortality, the deferral of annuity payments allows for the accrual of interest on the premium payments.

Getzen indicated to the Council that he does not include home health care benefits in his plan due to the difficulties he believes would be associated with determining entitlement for such services and his concern regarding the potential induced demand that availability of such benefits could create for these services. Getzen also indicated, however, that the annuity payments provided to participants after age 75 could be used to purchase home health care services.

Managed Care Approaches.—In addition to financing and underwriting the cost of long-term care services, managed care plans also coordinate and directly provide such services. Social/health maintenance organizations and continuing care retirement communities are two different approaches to the managed care concept. In addition, Northwestern National Life Insurance Company is developing a product called Lifescope which will provide participants with managed care and benefits from birth to death. These three managed care approaches are briefly described below.

Social/health maintenance organizations

The social/health maintenance organization (S/HMO) is a managed system of health and long-term care services, whereby a single organization assumes responsibility for a full range of acute inpatient, ambulatory, rehabilitative, home health, and personal care services under a prospectively determined, fixed budget. Essentially, a S/HMO resembles an HMO except that senior citizens comprise 100% of its membership and long-term, as well as acute, care services are provided.

S/HMOs are currently in the experimental stage. Four S/HMOs began operating in early 1985 as part of a demonstration project funded by the Health Care Financing Administration (HCFA) and coordinated by Brandeis University. These four demonstrations, in Long Beach, California; Portland, Oregon; Brooklyn, New York; and Minneapolis, Minnesota are scheduled to end in 1988.

Elderly individuals residing in the geographic areas selected as demonstration sites who participate or are eligible to participate in Medicare Parts A and B are eligible to enroll in an S/HMO. Prepaid Medicare and Medicaid funds and member fees are used to finance the cost of the services provided. Medicare reimburses the

S/HMOs 100% of the average per capita cost it pays for traditional health care for the elderly living in that geographic area, rather than the 95% reimbursement rate provided other HMOs. In addition, enrollees are charged a monthly fee ranging from $25 to $40 and pay some copayments and deductibles. To help underwrite risk on the demonstration sites, HCFA is providing reinsurance for the three years of this project.

A few commercial insurers are also exploring the possibility of offering a long-term care optional benefit to their HMO enrollees. Data from the four S/HMO demonstration projects will be useful to such insurers.

Continuing care retirement communities

Continuing care retirement communities (CCRCs), or lifecare communities, provide their residents with a range of residential and social as well as health services in exchange for an initial entrance fee or prepayment and, typically, an additional monthly fee. Estimates as to the number of such communities, which are located throughout the U.S., range from 300 to 600. Most CCRCs are affiliated with another institution, typically a nonprofit religious organization, although interest in their development is growing within the for profit sector.

Both the level of benefits provided and prices charged vary considerably among CCRCs. Initial entrance fees range from $60,000 to $125,000 and up, and monthly fees are usually over $1,000. Similarly, although CCRCs do provide residents with access to a continuum of care using on-site facilities, benefits range from full service to more limited service in terms of copayments and cost-sharing requirements. For example, chronic care services, such as skilled nursing care, may be provided either as part of a total prepaid package or for an additional charge over the usual monthly fee. In over half of the CCRCs, however, the monthly payment covers care in the community's nursing facility if it becomes necessary.

Lifescope

Northwestern National Life Insurance Company is developing an innovative program called Lifescope which would provide total managed care and benefits to individuals during their working years and into their retirement. As currently conceived, Lifescope would be a flexible, or "cafeteria-style" plan in which subscribers are guaranteed a set of core benefits—including acute medical care, life insurance and disability benefits—and then pay extra for additional coverage. The program is intended to allow subscribers to adjust their helath benefits as their needs change with advancing age.

It is anticipated that Lifescope would be marketed to employers as an employee fringe benefit. In addition to paying the premiums required for health care coverage during their working years, employees, and possibly their employers, would make payments to an employee retirement fund. Payments to this fund would accumulate interest over the employees' working years and then be used to finance their health and long-term care needs during their retirement. Northwestern National envisions the employee retirement fund as portable, enabling those who change jobs to continue to invest in it.

In regard to the long-term care component of the program, a representative of Northwestern National indicated to the Council that emphasis will be placed on assisting individuals in maintaining their independence to the extent possible. In addition to coverage for institutional skilled, intermediate and custodial care, home health and other support services such as transportation, meal preparation, and home maintenance would also be covered.

Lifescope will draw on the S/HMO concept by contracting with organized provider delivery systems, such as HMOs and preferred provider organizations, to provide subscribers with total managed care. It is anticipated that participating providers will agree to reduced rates and will share in the financial risks of the program. Northwestern National recognizes that it will have to contract with organized provider systems across the country, as retirees often relocate.

The representative of Northwestern National also indicated to the Council that several employers have indicated an interest in Lifescope. During 1987, a pilot test of the program is planned with a few such employers.

Cash accumulation approaches.—In contrast to the indemnity insurance plans and managed care approaches discussed above, cash accumulation instruments involve little or no risk sharing. Rather, they provide individuals with a mechanism for saving money for their future long-term care needs. Home equity conversion, including sale/leaseback arrangements and reverse annuity mortgages, and health individual retirement accounts, are examples of such financing instruments and are briefly described below.

Home equity conversion

Three-fourths of all households headed by the elderly are owner-occupied, and the average equity for each elderly homeowner exceeds $50,000. Even among the elderly poor, 65% are homeowners and 22% of the poor and 32% of the near-poor have more than $50,000 in net home equity. The purpose of home equity conversion mechanisms is to enable homeowners to convert their home equity into income while still living in the home. Such income could be used by the elderly to purchase long-term care services, particularly home health care in lieu of institutional care. Sale-leaseback arrangements and reverse annuity mortgages are the two basic types of home equity conversion.

In a sale/leaseback arrangement, a home is sold to a buyer, but the seller retains the right to rent the home for life. Typically, the buyer provides the seller with a lump sum payment. A reverse annuity mortgage (RAM) is a loan against the equity of a home that provides the borrower with monthly payments rather than a lump sum amount. Repayment of all principal and interest is deferred until the end of the loan term, the sale of the home, or the death of the borrower. According to one source, as of 1984, approximately 200 private reverse annuity mortgage transactions had occurred in the U.S.

Health individual retirement account

A health individual retirement account (HIRA) is another cash accumulation instrument which could be used by individuals to earmark personal savings for health care needs, including long-term care expenses, after retirement. The AMA already supports the expansion of the existing IRA mechanism to provide supplemental funds for health care expense on retirement, as part of its proposal for financing the health care of the elderly (Board of Trustees Report MM, A-86). Under AMA's proposal, all individuals would be allowed to contribute a tax deductible amount of $500 ($1,000 for husband/wife) to an IRA. The contribution limits would be adjusted annually.

After attaining eligibility age, any funds withdrawn from such IRAs for health care expenses would be tax-free. In addition, individuals below eligibility age who become permanently and totally disabled could also withdraw funds for health care expenses tax-free. Eligible health expenses would include, but not be limited to, health insurance premiums for "wrap-around" coverage of deductibles and coinsurance, direct payment of such cost-sharing amounts, or expenses of long-term care.

As at present, under AMA's proposal individuals could also elect not to withdraw their IRA funds but to preserve them for their estate if desired. Any funds remaining in an IRA on an individual's death would revert to that person's estate.

Family Support.—As indicated in Board of Trustees Report R (A-86), "AMA Policy and Programmatic Activities for an Aging Population—Status Report," families provide an estimated 75% of in-home care to the chronically ill elderly at significant personal expense. Once disabled family members enter a nursing home, however, families can be virtually free of any financial obligation. The ability of the family (other than one's spouse) to contribute to the cost of nursing home care is rarely considered in determining Medicaid eligibility for nursing home payment.

Some states have begun to explore mechanisms for imposing financial obligations on family members for nursing home care. Policy analysis in this area could focus on the advisability/feasibility of requiring relatives to pay a certain portion of nursing home services and of providing financial encouragement to families (e.g., tax incentives or direct payments) to maintain their chronically ill relatives at home instead of placing them in a nursing home whenever possible.

CONCLUSION

Adequate mechanisms for financing long-term care for persons in all age groups are needed. Given the fiscal constraints being experienced by the public sector, it is likely that the private sector will play an increasingly important role in meeting this need. This report provides suggestions as to the types of services which could be covered in a long-term care financing program and describes a variety of both operational and proposed private sector initiatives for financing long-term care.

With this informational report as a base, future reports to the House of Delegates will identify the strengths and weaknesses of the identified private sector initiatives for financing long-term care and present recommendations on this issue. The Council on Medical Service, as well as other policy units of the Association, will continue to assist in formation of policy on this critically important issue.

REPORT OF THE COUNCIL ON MEDICAL SERVICE—REPORT: E (A-87)

Subject: Special Payment Arrangements for Low-Income Medicare Beneficiaries.
Presented by: Robert D. Burnett, M.D., Chairman.
Referred to: Reference Committee A (H. William Porterfield, M.D., Chairman).

At the 1986 Interim Meeting, Substitute Resolution 68 was adopted by the House of Delegates. The resolution asks the AMA to continue its study of state and county medical society programs designed to provide affordable health care to low-income Medicare beneficiaries and to study the specific issue of waiver of Medicare deductibles and copayments in cases of financial hardship. This report informs the House of Delegates of the results of the study.[1]

VOLUNTARY MEDICARE ASSIGNMENT PROGRAMS

Physicians have traditionally demonstrated a high level of sensitivity in providing needed medical care to the poor. Physicians have been particularly responsive to the need to accept Medicare's approved amount as payment in full for financially disadvantaged Medicare beneficiaries, as recommended in Board of Trustees Report LL (A-84). Such physician efforts have been facilitated through the initiation of programs by a number of state and local medical societies to assist physicians in identifying Medicare patients who need acceptance of assignment.

Typically, these programs involve a cooperative effort between a local medical society and a local senior citizen organization. The senior citizen organization usually verifies a beneficiary's financial need for such special payment arrangements, based on an application from the beneficiary, and presents those qualified with a special card endorsed by the medical society. The medical society usually encourages the cooperation of member physicians in the program and compiles a list of physicians agreeing to accept assignment upon presentation of the card. Examples of such programs include those established by the Fairfield, Hartford, and New Haven County Medical Societies (Connecticut); the Ada County Medical Society (Boise, Idaho); the Tulsa County Medical Society (Oklahoma); the Ohio State Medical Association; and the State Medical Society of Wisconsin. A number of other local medical societies will refer beneficiaries to physicians who accept assignment either routinely or when needed, without conducting special programs to verify need.

In April 1985 and October 1986, the AMA sent communications to state and county medical societies encouraging further development of such local voluntary assignment programs. Informational materials on existing programs were sent with each of these communications to assist local societies. Since programs of this nature assist physicians in providing affordable health care to needy elderly individuals, the Council on Medical Service believes that the Association should continue to promote their development throughout the Federation.

VOLUNTARY WAIVER OF MEDICARE COPAYMENT AND DEDUCTIBLE

As requested by the resolution, the Council has also studied the issue of the waiver of copayments and deductibles for financially needy Medicare beneficiaries. As part of this study, the AMA has sought clarification from the Health Care Financing Administration (HCFA) regarding its policy on this issue. According to information received from HCFA, current Medicare instructions to carriers to allow for a physician to waive Medicare's copayment and deductible for financially disadvantaged beneficiaries on a case-by-case basis. The instructions do contain prohibitions against such waivers on a routine basis (Section 5220 of the Medicare Carriers Manual).

HCFA has indicated that carriers are expected to review all situations where they have reason to believe that a physician is waiving deductibles and coinsurance amounts for beneficiaries consistently rather than on a case-by-case basis. Such review is intended to determine whether such action constitutes a "routine" overall reduction of the physician's usual charges for the type of services provided. If it is determined that such a "routine" reduction of usual charges is occurring, a physician's customary charge profile is to be reduced. The physician also is at risk of being suspended or excluded from the Medicare program or of being subject to criminal prosecution by the Department of Justice for misrepresentation and fraud.

HCFA instructions to carriers do not, however, define the term "routine" with respect to such reduction in charges. In discussions with the Council, a HCFA representative expressed the view that such flexibility was preferable to an arbitrary percentage cut-off point, since physicians practicing in economically depressed areas

[1] Past House Action: I-86:401; A-84:158-177.

might well exceed that percentage cut-off even though their waiver decisions were being made on a case-by-case basis. That representative also indicated that virtually all sanctions against such routine waivers to date had been imposed against suppliers of durable medical equipment which had advertised their willingness to waive such copayments for all beneficiaries.

The Council believes that, in addition to voluntarily accepting assignment for low-income beneficiaries, it also is desirable for physicians to waive Medicare's copayment and deductible on a case-by-case basis for beneficiaries experiencing exceptional financial hardship. In the view of the Council, current HCFA policy does allow physicians the latitude and flexibility to make such waiver decisions on an individual basis. However, the Council believes it is extremely important for any physician who is contemplating such case-by-case waivers to discuss any proposed waiver practice with the carrier. Assurance should be obtained that this practice will not affect fee profiles or create a risk of sanctions. This is particularly true for physicians with a significant number of patients meriting such arrangements.

The Council will continue to monitor HCFA's policy regarding the waiver of Medicare copayments and deductibles for financially needy beneficiaries, and will report further to the House on this issue as appropriate.

PHONE: 753-6646

GENERAL AND
VASCULAR SURGERY

WILLIAM T. RICE, M. D., F. A. C. S.
P. C.
1827 NORTH MICHIGAN AVENUE
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48602

July 22, 1987

Senator Donald W. Riegle, Jr.
United States Senate
105 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Riegle:

Thank you for your letter of July 15, 1987 regarding your efforts to provide medical care to the poor citizens who have no medical insurance. This effort should have the highest priority. It is an extremely difficult and complex matter, and some attempted remedies have only added cost and confusion.

I do have some proposals to improve the situation.

If the patient load is evenly distributed among practicing doctors in the larger cities such as Flint, Saginaw, Lansing, Grand Rapids, Detroit etc., the doctors should be able to provide their services free of charge - if there is full participation.

Hospitals and laboratories could furnish clinic space and reduced charges to these people.

Required consultations should be left to the participating doctors. Required consultation on proved gallbladder disease or hernias is a waste of money if done only to meet a government requirement.

Mandatory laboratory work should be determined by the attending doctor - not by hospital or government rules. Examples of this are required chest x-rays and EKG's on everyone 40 years of age and older. This is mandatory in some of our hospitals in Saginaw and elsewhere and is a tremendous waste.

The "gate keeper" system of medical care, requiring the patient be seen first by the family practitioner is ridiculous and costly. The "gate keeper" is strongly tempted not to seek essential help, to withhold important laboratory studies, and otherwise delay help.

The "gate keeper" admits too many patients to the hospital and then moves much to slowly in obtaining workup and consultation, rather than sending the patient to a consultant who can get the workup done and initiate treatment from his office. This abuse adds immeasurably to the cost of medicine. Days or weeks of delay.

Doctors who owe the government time or money for medical school loans should participate fully in providing care to financially needy patients. This would mean good experience for doctors and good care for the patients.

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GENERAL AND
VASCULAR SURGERY

WILLIAM T. RICE, M. D., F. A. C. S.
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1827 NORTH MICHIGAN AVENUE
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48602

July 22, 1987

I'm fully aware of some of the difficulties you face in your efforts to provide good medical care to the poor and needy, but urge you to keep trying. It's the duty of the Congress and the medical profession to do so.

Sincerely,

William Rice

William Rice, M.D.

WR/sl

Shirley A. Robinson
9200 S. Morrish
Swartz Creek, MI 48473
(313) 635-3683
June 23, 1987

Honorable Senator Don Reigle Jr.
Eastern Regional Office
Sabuco Building, Suite 910
352 S. Saginaw Street
Flint, MI 48502

RE: Hearing on Health Insurance for Underinsured
Held June 22, 1987, which I attended

Dear Sir:

I am glad to see that the government is finally starting to get concerned for people with no insurance or are underinsured. My family fits into the latter category.

I am 36 years old and have worked for 16 years, up until 1985 when my blood disorder no longer let me work. My husband was injured at work 9-28-84 on the job and is currently receiving workman's compensation every week. Under workman's comp we do not receive the same exact benefits as if he was still working. We have an attorney working on this case but in the mean time things are very tuff and there is a lot of stress put on both of us.

I have hypogammagobulinenima, which means I do not produce the normal amount of IGG white cells to fight infection. I have had over 10 surgeries and 200 different tests and X-rays. I have cronic sinuitis, bronechiectasis, condyloma acuminata, cervical dysplasia, herpes labialis, herpes genitalis, herpes zoster, history of liver disease with previous biopsy, common variable immunodeficiency, and anemia. This means that I am currently receiving 4 units of plasma every 4 weeks to help raise my blood level which is between 300/400, normal is 500 to 15,000. I have to see the doctors in Ann Arbor every month to monitor how I am doing. I have been told that I'm prone to develop cancer and that I would not be able to receive chemotherapy because that reduces your white count.

When I was working I execellent insurance and so did my husband. The only insurance coverage that we can get now is BCBS basic comprehensive; which does not cover perscriptions or office calls. Our old insurance had major medical, perscriptions, eye glasses, and dental coverage. We are paying our own premiums each month and have been since May of 1985.

My husband's employer took us off their group plan as of 12-31-86 and we were paid up until 1-1-87. The convereion plan that they offered to us was not worth the paper it was written on. Right now we have incurred $5,952.42 in medical bills. That includes premiums, perscriptions, office calls, doctor ordered tests, plasma transfusions every 4 weeks, etc.

January 22, 1986, I found out that my daughter had a tumor and she had it removed right away. The doctor has diagnosised her as have

histocytosis X syndrome, which means she is prone to produce tumors of the bone so she cannot play in any contact sports or games or get hit on the head. She has a hole about the size of a quarter in her skull and I have her blood checked in Ann Arbor every 6 months to make sure nothing is going on. She has the most benign form but I still worry about her since she is my only child, Marie is 13 years old.

I agree with your program that you talked about on Monday but I might add that putting perscriptions and office calls into the bill would also help so many people like us. Perscriptions for myself alone for one month is $150 and I have to get them weekly.

We have tried to get Medicaid assistance and the spend down is $2856 before they will help us. They say that $985.44 per month is too much even considering our expenses are at 65% debt ratio. We have tried to get our home remortgaged 3 times to be able to pay our bills and they don't consider workman's comp an income.

If VA and VA Trust Fund hadn't helped we would have lost our house at the beginning of this year.

I have a Social Security case pending and thanks to your office the Law Judge heard my case on Monday June 17, 1987, and said that he would make a decision within the next 90 days. My file was sitting in the inactive pile and had the wrong social security number on it.

Thank you for being a very concerned and caring Senator. We need more people like you in the government.

Sincerely yours,

Shirley A. Robinson

Shirley A. Robinson
A VERY CONCERNED CITIZEN

cc: President Ronald Reagan

SAGINAW COUNTY
CHAMBER OF COMMERCE
WE MEAN BUSINESS
901 S. WASHINGTON AVE. / SAGINAW, MI 48601 / 517-752-7161

July 23, 1987

Senator Donald Reigle
105 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Reigle:

Thank you for rectifying the error concerning the hearing schedule on health insurance for the uninsured and underinsured. This is certainly very important to all businesses and we appreciate the opportunity to speak on the issue.

Economic vitality is a responsiblity that America's businesses have gladly accepted ever since our forefathers adopted Adam Smith's theories of economic survival in a free society. Mr. Smith knew that an excess of interference from government could destroy the balance that was needed for our economic system to prosper. Mandating of employee benefits, including health insurance, is a clear example of what was feared two centuries ago.

Requiring employers to pay the cost of social programs will lead to a major deterioration in our long-run economy. Federal spending and government regulation are out of control, and it seems that there is little hope that hard choices are going to be made to bring it back in line. As a result the costs of carrying out these social agendas are arbitrarily being placed on the backs of business people throughout this country.

Health insurance is one of those programs which is being unfairly handed to our employers. America's businesses are already paying on average $1460.00 per employee per year on health insurance premiums. Additional burdens in this area will not enhance American competitiveness and will further subvert our attempts to enhance our nation's economic standing.

Senator Kennedy has said, "the time has come to require all businesses in America to offer health insurance to all their workers and dependents as a condition of doing business." This phiosophy is not in best interests of the American people. The concept of adequate health insurance for all is a good idea and needs to be considered, but I would like to alter the philosophy of Senator Kennedy and many others in Washington just a little. The time has come to require members of the United States Congress to prioritize and spend accordingly so that our government will be able to provide all its' people with the services and benefits they are deserving and worthy of.

Michigan's businesses cannot afford any more prohibitive costs. Our state is losing high paying jobs and replacing them lower paying ones because entrepreneurs have not been given the encouragement necessary to locate and expand in our state. If business is given the opportunity to conduct business and not be be saddled with the additional costs of major social programs, America's businesses will respond and create and retain the jobs that are so vital to our future.

Again, thank you for allowing us the opportunity to respond the issue of health insurance. It is an issue our chamber is watching closely and we hope that you will give careful consideration to our point of view.

Thank you,

Duane

Duane G. Marsh
Vice President

302 Kensington
Flint, Michigan 48502
Phone 313-762-8000

St. Joseph Hospital

July 22, 1987

Senator Donald W. Riegle, Jr.
c/o Joan Huffer
105 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator:

I received your letter regarding Congressional hearing on health insurance for the uninsured and underinsured citizens of Flint. My feelings concerning this subject are somewhat ambivalent. In my capacity as an Emergency Department physician, I see many patients who either have no insurance whatsoever or who are inadequately insured, either by their own volition or under some Federal or State insurance programs. My ambivalence derives from the fact that frequently we see patients who have insurance of some nature and who abuse the system feeling that since they have such insurance they are entitled to medical care for any problem and at any time. We see patients who will go from one facility to another because they were not given the type of answer or treatment that they desired. This is not that the treatment was inadequate or erroneous but that such patients either wanted certain medications or drugs, time off from work, an excuse not to go to work, or inappropriate hospital admission. Such patients think nothing of going to two or three facilities within one twenty-four hour period. I feel that there will always be such patients in the system and that the medical profession has dealt with such problems for many years whether or not patients are paying or not paying for the service.

On the other side of the coin, we see many responsible patients who delay their care because they feel that they may not be able to afford such care. They, therefore, hope that in time their malady will cure itself and they will not put themselves in the position of running up a debt with which they cannot cope. Unfortunately, this frequently results in the patient becoming ill to the point where it is a threat to their life and they eventually must seek medical care. At this stage, the treatment is much more intensive and sometimes the outcome is not as good had the patient sought early medical attention.

A third problem that I have observed is that some physicians who are very caring and excellent physicians decline to see some patients who have Medicaid-type coverage because the reimbursement is so inadequate that, according to these physicians, it actually costs them money to see such patients. They, therefore, refer these patients to hospital emergency departments where the policy is that any patient who presents themselves must be seen, evaluated, and cared for appropriately. This sometimes puts an unnecessary burden on the emergency department and it is sometimes humiliating to the patients.

Because of the above considerations, I guess I would have to favor some type of universally-available insurance that would provide coverage for all citizens in this country. I realize that what I am saying may be looked upon as heresy by some but I have read about and seen some such systems in other countries work out quite satisfactorily. The systems in the Scandinavian countries, in particular, seem to be very workable. The main criticism I hear is that there are long waits for service and, in particular, patients who require elective procedures must wait a particularly long time for such service. Hopefully, if such a system were developed in this country some of these problems could be overcome. In any event, with what I still perceive as a lot of wealth and ingenuity in this country, I think that we ought to be able to provide more adequate care to greater numbers of patients which would be comparable to some of the other systems of universal medical care throughout especially Europe.

I hope these thoughts on this subject will be useful to you. If I can be of any further help, please feel free to contact me.

Sincerely yours,

ST. JOSEPH HOSPITAL

Alan L. Morgan

Alan L. Morgan, M.D.
Director
Emergency Medical Services

ALM/bjs

THE URBAN LEAGUE OF FLINT
202 EAST BOULEVARD DRIVE FLINT, MICHIGAN 48503 (313) 239-2195

June 12, 1987

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Hon. Donald W. Riegle, Jr.
U.S. Senator
Sabuco Building, Suite 910
352 S. Saginaw St.
Flint, MI 48502

Dear Senator Riegle:

I am pleased to respond to your invitation to state our concerns with the problems facing the uninsured and underinsured. Our concerns are in conjunction with those expressed in a March proposal which was submitted to the Medical Services Administration of the Michigan Department of Social Services.

The Urban League of Flint was one of eleven community agencies and organizations which met and provided input for the eventual development of the "Health Care Access Project". Pages three, four and five of that proposal are enclosed for your review; issues and statistics included dramatically portray a current dilema, and a forthcoming expansion of problems as the economic/employment picture worsens. "Genesee County will experience the economic dislocation of many citizens employed in the automotive and automotive related business. A portion of these citizens will move from employment which provides health care to employment which does not provide this benefit".

So as good paying jobs are replaced with low paying jobs, the loss of health benefits as well is a frightening and depressing prospect.

You need only to refer to studies done in Youngstown Ohio "Developing a Human Services Response to Economic Crisis" - a working paper, October 18, 1978; or Psychological Distress and Well-Being of Workers in Distressed Communities" - Center for Urban Studies, to gain insights to the generic consequences of losing family income and health insurance.

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PAGE TWO

As an advocate for minority persons and issues, I am deeply worried for black, poor and disadvantaged families who are entirely without health resources. Unemployment (at least 20% in the black community), the extent of poverty (25% of all county residents), household income (for many less than $10,000 per household), add up to a bleak and foreboding future for a significant portion of our population. Because the costs of indigent health care has become almost cost prohibitive for local hospitals and health care providers, many are doomed to living with poor health and shorter life expectancies. It is estimated that three-fourths of those without insurance are not covered by Medicaid either.

I would appreciate this becoming part of the hearing record; I will do my best to attend this important hearing.

Sincerely,

Melvyn S. Brannon
President

MSB;amf
Enclosures

The Project

The goal of this project is to improve access to health care for citizens who currently are without health care coverage. This population includes Medicaid ineligible citizens and citizens in low income employment which does not provide health coverage as a benefit. Many of these citizens may be receiving General Assistance (GA) or leaving Aid to Families with Dependant Children (AFDC) assistance.

The project will combine funds from Genesee County's Resident County Hospital (RCH) program with those from other sources including the state funded GA Medical program, a special $500,000 appropriation included in the budget of the Michigan Department of Social Services, and premiums paid by participating employees and their employers. Other funds may be brought to bear as the project takes shape.

A strong, representative local consultation committee will be assembled to act in a steering capacity throughout the project.

Problem Statement

Some citizens are without adequate coverage for health care. A recent survey in Genesee County estimates the number of citizens without any type of coverage to be approximately 22,000 (Genesee County Data Base, PURA, 1987). Some citizens despite adequate resources, choose to be without coverage. Many other citizens have no choice.

Individuals are without coverage for a number of reasons. Public programs, such as Medicaid, have eligibility requirements which restrict participation. Funding levels for these programs have not kept pace with the need. Not all employers provide health care coverage as a benefit of employment. Where coverage is provided, it may not be comprehensive in its scope of coverage or cover dependents. Coverage may not be affordable for some. Typical of those without coverage are those without income or with little income, dependents, and female headed families.

Many individuals in Genesee County currently receive health care from providers who are uncompensated or who subsidize the cost of undercompensated care through donation of time, materials and overhead costs. But the willingness of providers to continue delivering or expand delivery of care to those unable to pay for care is decreasing. Bad debt alone, in the case of one provider for fiscal year 1986 equalled nearly $6 million.

Providers' ability to continue to provide care in this fashion is becoming limited due to the rising cost of providing care and purchasing malpractice insurance and the newly competitive environment in the health care industry.

The population of medically indigent and underinsured citizens is rapidly increasing. Economic and social conditions in Genesee County will change over the next few years. Genesee County will experience the economic dislocation of many citizens employed in the automotive and automotive related business. A portion of these citizens will move from employment which provides health care to employment which does not provide this benefit. General Motors (GM), for example, has indicated that over 8,000 of its employees will be laid off in 1987. An additional 13,000 employees of General Motors may be laid off in subsequent years. It is estimated that each laid off person has a family of 2 - 4 members.

Health care for the uninsured, underinsured and unemployed within Genesee County has been described in some detail in a report by the Genesee-Lapeer-Shiawassee Health Planning and Development Agency Project Advisory Board. Attachment 1 is a copy of this report.

Size and Scope of the Potentially Eligible Population

The Michigan Department of Management and Budget estimates the population in Genesee County to be 443,637 in 1987. Estimates of the size and scope of the uninsured population in Genesee County vary and may best be measured by proxy. The uninsured population are counted and duplicated in the Department of Social Services, Michigan Employment Security Commission and the County Census Statistics.

The Department of Social Services expects its caseload size to remain constant during the project period. Although the state predicts a decline in overall caseloads statewide, the decline will be offset by GM layoffs in Genesee County.

The Current GA caseloads are:

7,356 active General Assistance Cases
9,106 active General Assistance Recipients

Statistical data for 1986 include:

376 approved RCH cases
761 AFDC case closures due to employment
511 GA case closures due to employment
12,882 denied applications for Medicaid
5,458 denied applications for General Assistance

The level of unemployment may serve as an overstated proxy of the number of uninsured. Unemployment in Genesee County by year for 1984 and 1985 is 12.1%, and 10.6%, respectively. Current unofficial estimates place unemployment at 9.5% or approximately 18,900 citizens.

The extent of poverty may be another proxy measure. In 1986, one quarter (25.1%) of residents lived in households in the county with incomes at or below poverty level. One household in six had income less than $10,000 (PURA, Data Base, 1986).

Availability of Funding

Funds to underwrite the administrative costs of the project will be provided by the Robert Wood Johnson Foundation under its Health Care for the Uninsured Program through its recent grant to the Michigan Health Care Access Project.

Genesee County budgets funds for the RCH annually on a calendar year basis. The table below illustrates Genesee County's past commitment to the RCH program. The Genesee County Board of Commissioners has budgeted $721,440 for calendar year 1987 and commits to a budget of $721,440 for year 1988.

Calendar Year	Adopted $Budgeted	Actual
1983	1,128,242	1,120,426
1984	1,038,402	1,038,402
1985	1,239,150	1,239,150
1986	721,440	2,064,233
1987	721,440	N/A
1988	721,440	N/A

Table 1: Genesee County Resident County Hospitalization Adopted Budget and Actual Payments 1983 - 1988.

For 1987, the County and Department of Social Services have moved away from the prior authorized DRG approach to a negotiated per person/day rate with each hospital in an effort to control costs. This approach is expected to continue in 1988.

With respect to the indigent population in 1983, in the five hospitals in Genesee County, total in patient care charges were $301,859,005, 14.6% of which ($44,026,591) were for indigent care.*

*Indigent care equals Medicaid + Title V + Resident County Hospitalization + Bad Debts (exclusive of charity care)

—— 1 ——

June 19, 1987.

C. S. Mott Community College
Marie Prahl Center
1401 E. Court Str.
Flint, Mich. 48503.

A. VILKS
3619 E. MARCUS DR.
SAGINAW, MI. 48603.

Dear Senator Riegle!

May be people do not complain loud enough about the question I am going to mention here and it may not be brought up this time on your conducted hearing on monday, June 22, 1987, either.

I would like to draw your attention to it, that it is one of the main and most important questions that should be tested, changed and stabilized when regulating the subject matter of medicare and other insurances. And that is: it has to be controlled, stopped and found a medium price for the doctors fee. It should not - by saying it literaly - be a robbery done to the ill, poor people, who have turned to the doctors for help. Besides, a person being in such a condition is willing to give his last penny and the doctors are happy to take it. Not only I, myself, but everybody, who has been seing a doctor, knows and sees, that the from doctor demanded pay for a 3-5 minute visit is incredibly high - $25.00 or $30.00 That is only for the so called „office call". The patients, of course talk about it, but that talk is only a discussion, that remains between them. The majority of them assume, that it is like a law what the doctor says, not only about the illness but also the pay - it is right and irrevocable. Often, because of the haste and superficiality is the diagnosis given by the

physician-wrong. It often gets discovered only after some months and the damage has already been done. Also unnecessary surgeries have been and still are done, because of the physician's greed for money. If the word „surgery" is ment, the pay is not small, it is not only in the hundreds, but most often reaches thousand and more of dollars. Neverthe-less Medicare, Blue Cross, Blue Shield etc. have settled to pay a certain sum for each physician's service. These sums are quite generous, but the doctors are never satisfied with them. They know, that the patient has some dollars too in the pocket and those should replenish their „poor" income. The patient has to pay the difference between the demanded from the doctor and the allowance from the insurance. For example: I personally have Medicare and Blue Cross and there has not been a time, when I would not have to pay the difference. And because of that I would have to find a 3rd insurance, which, of course, could not be found by not paying for it. There is also only a small hope, that three insurances would be sufficient.

I am talking here in the name of two persons, as my wife also is seeking help from doctors and is familiar with their activities in the above mentioned ways. Of course, there is also information from other people, that coincides with the mine. Some physicians (I say some, as I know only some cases) are not satisfied with the usual fee, it is too small for them and therefore they report to Medicare things, that the patient has never received, like lab. work or something, that has been considered to being performed in his office. And in those

cases Medicare pays for the lab. work that has never been done. That kind of cheating I have found by 2 Saginaw doctors. Of course, these „lords" have always their excuses: the secretary-nurse has made a mistake and has notified Medicare. But no mistake has been made - there the Doctor's wife or a longterme, faithful nurse have been taught this kind of money making. And not only I have had that kind of cases, but people, who do want avoid a scandal with their doctor, say: „I don't care, it is not my money what the doctor receives from Medicare." One must think, how many of those cases appear on the whole continent and what Medicare suffers from it.?

Of course, the doctors have big expenses, but that is not an excuse for high fees and the other here mentioned affairs. The doctors do not like, that they now also have become subjects from whom is asked responsibility about the work they have done. Because of that they have to have malpractice insurance. With this arrangement the patients are somehow protected and the doctors are forced to think more about the patients. My personal observations show, that it has not much influenced them, as they are still short of time and in haste with the treatment of patients and deciding the diagnosis.

The waiting rooms of physicians are crowded with patients. Before coming to their waiting patients, the doctors have been busy in the hospital either with surgery or with visiting the bed patients. That make it impossible for them to arrive in time to the full waiting room with patients.

Without any scruples the doctor can afford that, because he is busy and patients have to take it.

As a result, the patient has to wait for his turn at least an hour and sometimes much, much more. About this kind of waiting, the patient, of course, complains. But, as I mentioned before, they have been accustomed to this situation and take it as a law, that it has to be like that. When the patient finally reaches the doctors examination room, the doctor spends with him several minutes. He has soon his hand on the door knob and that means the conversation, as short as it was, has now ended. An answer of a question, that often remains open, is not anymore possible to get, or it is short and abrupt, as the doctor has to hurry to other patients. The majority of doctors have a wonderful arrangement. Each has 3-4 rooms, where the patients get led in by a nurse. Then the doctor starts visiting one room after the other and collect the money. Of course, the patient has to pay at the cashiers window - either paying cash or the doctor receives it from Medicare, Blue Cross etc. But the difference has then to be paid by the patient later.

There could be written many important cases with facts as examples about this situation, but I doubt, that anybody would be seriously interested in it. This situation has existed many 10 or even 100 years and the main answer is: there can nothing be done.

Thinking about all mentioned, there arise important questions: Why are the waiting rooms of the doctors crowded with patients? Why are the doctors allowed to cash from the unhappy, ill

people so big sums of money for the so called – „office call" and surgery? Why do have the patients to wait for an appointment (sometimes in serious cases) for weeks or months? Why after such a long waiting, including the one in the waiting room the patient gets from the doctor such a short time for the examination?

There are very few doctors, usually with gray hair, who spend regularly more time than 5 minutes for the examination of their patients. These doctors call a three minute examination – „a money collection". And this term „collection" I have borrowed from these doctors. They know each others work and hear it from the patients, who have the chance to come over to them.

To the above mentioned questions with the word – „why" is only one answer: there are not enough doctors in order to get rid of the mentioned wrong doings and create competition in this profession. Now there does not exist competition and the doctors know, that the patients have to endure, what the doctors decide for their own good by creating for themselves a greater income.

There are many highschool graduates and many, many of them have a great interest in studying medicine, but have no chance to be accepted in the faculty of medicine. These faculties are accepting only a certain number of students every year. It has to be asked again – why? And we all know – why? The doctors are organized already from long time ago and hold in their hands all the privileges, that concern their profession. They also decide the number

of the new acceptable members of the medical schools.

Breaking these privileges would be a great service to mankind and to the American Nation in different ways and means. The opposition of the doctors would be unbelievable, as they would face a great responsibility in order to survive the competition, they now ignore and do not practice.

The whole busy business would end as soon as there would come enough of young doctors, who would worn more with interest than with collection of money.

By talking to the doctors about their high fees their all only answer is, that they have gone to school for 18 years and studied, and now it supposed to be time to receive something back. I have pointed out, that the expenses they have had for 18 years they cash back from the patients in a year. The explanations of the doctors have no salad ground, as there are engineers, chemists, phisicists and other professionals, who also spend 18 years of education and their income does not come close to the one of the doctors.

It has to be mentioned once more, that the physicians work with sick people, who do not take much, but pay what they are asking.

I understand, that you can not so simply change it. The physicians are wealthy people, who will fight with all kind of unacceptable arguments in case, their present privileges and behavior would become threatened to undergo changes.

In my explanations and facts it can be seen how and where the Medicare money flows.

My wish was, that you would receive this letter before the hearing.

Respectfully, Alexander Sr/Jr

VISUALLY IMPAIRED CENTER

725 Mason Street Flint, Michigan 48503 Phone (313) 235-2544

Senator Donald Riegle
352 S. Saginaw
Flint, Michigan
49502

June 22, 1987

Dear Senator:

I attended the hearing today on the uninsured and underinsured. I was representing the Visually Impaired Center in Flint. I had to leave before I had a chance to testify so I thought that I would write you a note to tell you what I had planned to say.

I work primarily with older people, many of whom do not have medical insurance. These same people often have very serious medical problems. I have one lady in particular who is 57 years old. She has heart problems, has had a stroke, is blind, and has some other medical problems. She is supposed to be on eight different medications. However, at the present time she is not taking any of them because she has no money to pay for them. She has no medical insurance. She has applied for Medicaid and for some strange reason has been denied. I have exhausted all resources trying to get help for this lady. She has been without her medication for a week. If she is without it much longer she will die. This lady is all alone in the world. She has no family and no friends who are able to help her. Unfortunately, I run into people in this position quite often in my line of work. I would appreciate anything that you could do to help people in this type of predicament.

Sincerely,

Judith De Jong

Judith De Jong
Certified Social Worker

July 20, 1987

Joan Huffer
105 Dirksen Senate Office Building
Washington, D.C. 10510

Attn: Donald W. Riegle, Jr.

Dear Mr. Riegle:

I am a staff physician at a city hospital in Flint. I do critical care medicine. This means that I am often confronted with the uninsured pati[illegible]. In the two years I have been here I have never used money as a reason to [illegible]fuse a patient. To my knowledge, my institution has not either. Speaking from the physician point of view, I must say that historically there have always been physicians like myself who are willing to care for the uninsured. I feel, however, that this has changed over the last decade and in the future will continue to change.

As long as the legal profession preys upon the medical profession, and the uninsured are <u>actively</u> solicited to search for reasons to initiate litigation, this group of people will have increased difficulty finding medical care.

I know of no physician who would knowingly harm a patient, either insured or uninsured. When the legal profession takes responsible steps to protect the medical profession as well as the patient, a significant part of this problem will be solved.

Every physician I have talked to on this subject feels the same.

I would be happy to hear of your progress on this topic.

Sincerely,

F. Wadenstorer

Frazer A. Wadenstorer, M.D.
13009 Croftshire Ct.
Grand Blanc, Michigan 48439-1541

FAW:cr

JOSEPH J. WILLIAMS (RETIRED),
Flint, MI, June 22, 1987.

DEAR SENATOR RIEGLE: This is merely a suggested form of financing catastrophic and long-term care. My wife is a cancer patient.

Several years ago while working, I bought an annuity plan with retirement income in mind. This year it matured and I had to begin withdrawal, as it was tax deferred. I filed my income tax in March, and made my estimated format for this year 1987. The annuity payments, I began in April. I did not think that at the time I originally filed that they may alter the estimates. Later I discovered that this annunity besides being taxable, put me in a different bracket under the NEW tax law and also made a portion of our social security taxable. So I had to increase the quarterly estimates to be within the percentage allowance, required by the new law.

My point is for Social Security recipients who have sufficient other income to make part of their Social Security taxable, could the income from that portion of taxed Social Security be applied to supplement the Medicare insurance rather than go into the general I.R.S. tax funds.

This would be taxing those who could better afford to pay. This together with the supplemental tax you alluded to might be enough to finance the program.

I am neutral on raising the tax from $17.90 to $21.90. If necessary use it too.

I had to leave the public hearing early due to my wife's health, therefore I thought I'd send you this idea, if you have not already considered it.

JOSEPH J. WILLIAMS.

FAMILY PRACTICE

LEWIN WYATT, JR., D.O.
G-5103 W. Pierson Rd.
Flint, Michigan 48504
Telephone: (313) 733-7503

June 22, 1987

Dear Senator Riegle:

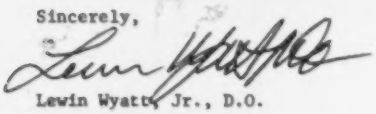
My name is Lewin Wyatt, Jr., I'm an osteopathic general practicioner practicing in Flint, and president of the Genesee County Osteopathic Association.

It is anticipated that with the pending layoffs in our area many will be placed in the ranks of the uninsured or underinsured. Several years ago when economic conditions in the Flint area caused an increase in those individuals without adequate health insurance, members of the Genesee County Osteopathic Association as well as members of the Genesee County Medical Society volunteered their services without regard for reimbursement. In anticipation of pending layoffs, members of our association have again agreed to provide care for those needy patients referred to them through our community service agencies.

With the large number of potential patients without any means of health insurance or ability to pay for health services, it is my hope that funding will be available to help defray the costs of providing care to these recipients.

My own frustrations in providing care for indigent patients has been in trying to gain access for ancillary diagnostic and treatment services. Funding will be needed for pharmaceutical, diagnostic, radiological and hospital services. It is not enough, as seen in some programs, just to provide for an office visit with a physician. I should be able to order a CT Scan for an indigent patient without regard for how the patient can pay for it just as I can for the patient with adequate health insurance. If, in this country, health care is a right, then the government must be willing to provide that health care.

Sincerely,



Lewin Wyatt, Jr., D.O.

Donald W. Riegle, Jr.
United States Senate
Washington, D.C. 20510

LW/lmw

Association for Voluntary Surgical Contraception

122 East 42nd Street, New York, New York 10168
Telephone: 212-351-2500
Cable: IAFORVS NEW YORK
Telex: 425604 (AVS-UI)

Testimony

Senate hearing on health care issues
Mott Community College, Flint, Michigan

June 22, 1987

Prepared by:
Jennifer Leeds
Program Officer
Association for Voluntary
Surgical Contraception

Formerly the Association for Voluntary Sterilization

The Association for Voluntary Surgical Contraception (AVSC) is a nonprofit membership organization. We began in 1943 out of the strong conviction that men and women should have the choice of voluntary sterilization available to them as a simple right.

We work toward this goal in the United States by undertaking or supporting programs in education, public policy, service, and research.

Voluntary surgical contraception (VSC), the most popular method of birth control in the United States, is widely available. Eighteen percent of all women ages 15-44 rely on either male or female sterilization services.[1]

Yet, there are many individuals unable to obtain permanent birth control. Nationally, the major barrier to voluntary surgical contraception is financial.

Total cost for female sterilization in an outpatient hospital setting in 1982 was $1275.[2]

For those with medical insurance, it is likely that the procedure is covered. Federal and state funds, although insufficient to keep up with demand, may be used to pay for sterilization services for Medicaid recipients.

But for those who do not have third party coverage, do not meet eligibility requirements for state funding, or do not have cash in-hand at the time of the procedure, voluntary surgical contraception is effectively denied.

AVSC is concerned about those individuals - the uninsured working poor - whose health care costs are not absorbed by any system.

We endorse efforts to provide access to adequate health care coverage for all individuals in Michigan so that those caught in between may have the option of ending their childbearing capacity permanently, if they wish to do so.

References

[1]W. D. Mosher and C.A. Bachrach, National Center for Health Statistics, Vital and Health Statistics, series 23, No. 12, DHHS publication no. (PHS) 86-1988, U.S. Government Printing Office, September 1986.

[2]M.T. Orr et al, "The Provision of Sterilization Services By Private Physicians", Family Planning Perspectives, Vol. 17, no. 5, September/Ofcotber 1985, pp. 216-220.

Cystic Fibrosis Foundation
Greater Michigan Chapter
104 N. Washington Avenue • Saginaw, Michigan 48607 • (517) 752-1144 (800) 292-7169

The following is a statement concerning the insurance problems of the Cystic Fibrosis patient:

Cystic Fibrosis is America's number one genetic killer of children and young adults. It is a chronic, degenerative disease that produces abnormal amounts of thick, sticky mucus that clogs the lungs and digestive system, interfering with the breathing and absorption of food. Each year, Cystic Fibrosis kills more children than polio, diabetes, multiple sclerosis, and muscular dystrophy combined.

The average life expectancy of a healthy child born today is 74 years. The average life expectancy of a child born today with Cystic Fibrosis is only 21 years.

These facts automatically put all Cystic Fibrosis patients into one insurance category - high risk.

Family incomes can be exhausted by medical bills relating to a Cystic Fibrosis child.

Children with Cystic Fibrosis are eligible for the Crippled Children's Program in Michigan whereby medical care and treatment is provided after medical eligibility is determined and evaluated according to financial eligibility.

Financial eligibility, according to information from the Crippled Children's Program office, is automatically approved if the potential recipient is: receiving Medicaid, or is a ward of the county, state or a private child place-

ment agency; or adopted, where the handicapping condition existed prior to the final adoption. If not automatically eligible, than financial participation is determined on the basis of gross income and family size and families are required to share the cost of their child's care through payment agreements with the state of Michigan.

Herein lies the major problem. Even though Crippled Children's Services will cover Cystic Fibrosis patients, including those over 21, it does not allow for patients who have medical problems not related to the disease. Examples of this would be the case of a CF young adult with severe arthritis that requires joint replacement. Since this is not related to CF, Crippled Children's Service does not apply. Another example is the CF patient in her early twenties who requires gynocological surgery. Crippled Children's does not apply. Nor does it apply to any type of psychiatric counseling that may be needed for family adjustment to the disease.

The base interpretation of this is that not all parents qualify for Crippled Children's Services.

The annual cost for caring for a Cystic Fibrosis child is between $10,000 - $15,000.00 annually for earlier stages of the disease and $100,000.00 per year in the later stages.

Therefore, health care is a constant burden for many

families with a Cystic Fibrosis child. There is an obvious need for legislation that will fill the many voids in the insurance programs as they exist.

Respectively submitted,

Roxann Guzak 6/22/87

Roxann Guzak,
Director
Genesee Valley Branch
Cystic Fibrosis Foundation

LAPEER COUNTY HEALTH DEPARTMENT
1575 SUNCREST DRIVE
LAPEER, MI 48446
313 667 0391

TESTIMONY

HEALTH CARE FOR THE UNINSURED ACT OF 1987

FLINT, MICHIGAN, JUNE 22, 1987

MY NAME IS JOHN NIEDERHAUSER. I AM THE HEALTH OFFICER FOR THE COUNTY OF LAPEER, A COUNTY OF APPROXIMATELY 70,000 PEOPLE. I NOT ONLY SPEAK IN SUPPORT OF BILL S177, BUT THE DESPARATE NEED FOR THIS ACT IS UNDERSCORED BY MANY FACTS. FOR EXAMPLE, SINCE THE PASSAGE OF THE OMNIBUS RECONCILIATION ACT, HOSPITALS HAVE BEEN FORCED TO BECOME FIERCELY COMPETITIVE, WITH THE RESULT THAT FEWER WILL ACCEPT UNINSURED PEOPLE. IN OUR OWN CASE, OUR ONLY LOCAL COMMUNITY HOSPITAL WAS FORCED TO INCORPORATE PRIVATELY IN ORDER TO SURVIVE. THE PROBLEM IS THAT UNINSURED PATIENTS ARE FOR THE FIRST TIME NOT EVEN PERMITTED ACCESS TO PRIMARY CARE.

TESTIMONY
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SPECIFICALLY, OUR PUBLIC HEALTH NURSES ARE SEEING A STEADY INCREASE IN DEMAND FOR CARE PREVIOUSLY PROVIDED UNDER SO CALLED "CHARITY" MEASURES. IN FACT, IT IS ONE OF THE PRIMARY REASONS THAT PUBLIC HEALTH TODAY IS SO SEVERELY OVERLOADED.

THE SECOND MAJOR FACTOR IS INTIMATELY TIED TO THIS PROBLEM. IF THE PUBLIC HEALTH SYSTEM IS BEGINNING TO CRACK UNDER SUCH PRESSURES, HOW CAN IT POSSIBLY HANDLE THE INCREDIBLE STRAIN THAT THE PENDING AIDS CRISIS WILL BRING? FOR EXAMPLE IT IS ESTIMATED THAT MINIMAL TREATMENT TODAY FOR A SINGLE CASE OF AIDS IS $200,000. AGAIN, IN OUR LOCAL CASE, OUR ENTIRE COMMUNICABLE DISEASE BUDGET IS NO MORE THAN $12,000.

A THIRD FACTOR HAS TO DO WITH THE WAY SOCIETY TREATS PEOPLE EMPLOYED PART TIME. BOTH LABOR AND MANAGEMENT OFTEN DISENFRANCHISES THE PART TIME EMPLOYEE FROM FRINGE BENEFITS. AGAIN, IN OUR OWN CASE, OUT OF FORTY HEALTH DEPARTMENT EMPLOYEES FIVE WORK THIRTY-TWO HOURS A WEEK AND ARE NOT ELIGIBLE FOR HEALTH INSURANCE PROVIDED BY THE COUNTY TO FULL TIME EMPLOYEES.

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LASTLY I WOULD LIKE TO SPEAK TO THE FUNDING ISSUE FOR THIS ACT. SPECIFICALLY TO THE PROVISION FOR POOL FINANCING TO COME AT LEAST IN PART FROM STATE AND LOCAL EXISTING FUNDING. ALTHOUGH IT CONCERNS ME THAT THERE SIMPLY ISN'T ANY LOCAL FUNDING, I AM FAR MORE CONCERNED WITH THE MECHANISM FOR FUNDING. THE PROVISION DIRECTING THE STATE TO PROVIDE SOLVENCY TO THE FUNDING POOL NEEDS TO BE SAFEGUARDED FROM MIS-INTERPRETATION. SINCE THE STATE MAY LOOK TO OTHER POLITICAL SUBDIVISIONS FOR FUNDS, AND IT HAS BEEN MY EXPERIENCE THAT THE STATE ROUTINELY PASSES ALONG COSTS, THERE IS RISK THAT THE ACT MAY BECOME ANOTHER GOOD INTENT GONE WRONG.

LEROY NICHOLS
EXECUTIVE DIRECTOR, GCCAA

IN TESTIMONY BEFORE
SENATE HEARING ON HEALTH CARE ISSUES
THE SENATE OF THE UNITED STATES
JUNE 22, 1987
(HEARING IN FLINT, MICHIGAN)

TO THE HONORABLE DONALD W. REIGLE, JR., OF THE U.S. SENATE, THANK YOU FOR THE OPPORTUNITY TO APPEAR BEFORE YOU TODAY TO SHARE URGENT CONCERNS ABOUT NEEDY AMERICANS, IN PARTICULAR, THOSE WHO ARE WITHOUT OR WHO HAVE INSUFFICIENT COVERAGE OF HEALTH INSURANCE.

PROBLEMS

A LACK OF A NATIONAL HEALTH POLICY AND A LACK OF A NATIONAL HEALTH CARE SYSTEM THAT COVERS INDIVIDUALS FROM BIRTH TO GRAVE, MANIFEST ITSELF IN MANY WAYS. TYPICALLY; A SCENARIO RUNS LIKE THIS: THE FAMILY'S BREADWINNER LOSES HIS/HER JOB AND IS LEFT WITHOUT HEALTH INSURANCE COVERAGE WHILE RECEIVING UNEMPLOYMENT COMPENSATION. UNEMPLOYMENT CHECKS MAY OR MAY NOT COVER EXPENSES BUT CERTAINLY WILL NOT COVER THE MONTHLY COST OF HEALTH CARE PREMIUMS. THE INDIVIDUAL COULD SPEND A YEAR WITHOUT MEDICAL COVERAGE -- WHICH COULD RESULT IN CATASTROPHI. IF EMPLOYMENT IS NOT FOUND BEFORE BENEFITS ARE EXHAUSTED THE HEAD OF HOUSEHOLD, NO DOUBT, ENDS UP ON PUBLIC ASSISTANCE WHERE MEDICAID IS AVAILABLE.

THE LACK OF ALTERNATIVES FOR WELFARE RECIPIENTS

MANY FAMILIES ON WELFARE WOULD CONSIDER OTHER INCOME OPTIONS IF OTHER HEALTH INSURANCE OPTIONS WERE AVAILABLE. FOR EXAMPLE, IF A FAMILY IS RECEIVING PUBLIC ASSISTANCE AND/OR IS THE BREADWINNER (USUALLY FEMALE HEAD OF HOUSEHOLD) IS OFFERRED EMPLOYMENT AND THE FAMILY'S INCOME INCREASES BUT THE EMPLOYER DID NOT PROVIDE A HEALTH PLAN OR

THE PLAN PROVIDES UNDER-INSURANCE, THE FAMILY WOULD OPT TO REMAIN ON WELFARE RATHER THAN CHANCE THE FAMILY'S HEALTH TO UNSTABLE OR NO INSURANCE. I AM SURE YOU CAN APPRECIATE THE DILEMA AND APPRECIATE THE DECISION OF THE BREADWINNER.

THE LIMITATIONS OF MEDICAID-DENTAL CARE

ONE OF THE FIRST NEGLECTS OF THE FAMILY WITH NO HEALTH INSURANCE IS THEIR TEETH. IF THE PAIN IS NOT THERE THE FAMILY IGNORES THE NEED FOR PREVENTION. BUT IF A FAMILY IS BARELY MAKING ENDS MEET, THE FAMILY WILL FOREGO PREVENTIVE DENTAL CARE. IN ADDITION, SOME DOCTORS AND PARTICULARLY DENTISTS WILL NOT TAKE PATIENTS COVERED BY MEDICAID.

PRESCRIPTION CO-PAYMENT AND ORTHOPEDIC SUPPLIES AND EQUIPMENT

WE THINK THERE IS SOMETHING WRONG WITH A HEALTH SYSTEM OR THE LACK OF ONE THAT TENDS TO ROB INDIVIDUALS OF THEIR LIFE'S SAVINGS, WHEN THEY EXPERIENCE POOR HEALTH. THERE IS SOMETHING WRONG WITH A SYSTEM THAT FORCES INDIVIDUALS CONSISTANTLY TO DEPEND UPON ASSISTANCE FROM SOCIAL AGENCIES TO HELP MEET THEIR HEALTH CARE NEEDS. AS IT STANDS NOW, SOCIAL SERVICES AGENCIES IN THIS COMMUNITY AND EVERY COMMUNITY ACROSS THIS COUNTRY ARE ATTEMPTING TO DEAL WITH THE COMMUNITY'S HEALTH PROBLEMS, FROM ASSISTING FAMILIES WITH PRESCRIPTION CO-PAYMENT TO ORTHOPEDIC SUPPLIES AND EQUIPMENT. FOR SEVERAL REASONS THE HEALTH SYSTEM DOES NOT COVER THOSE NEEDS OF OUR CLIENTS. HOWEVER, SOCIAL AGENCIES IN THE COMMUNITY ARE CALLED UPON FOR HELP. IN MANY, MANY CASES, THE HELP

BEING SOUGHT IS TOO MUCH FOR ONE AGENCY TO PROVIDE, AND WHAT USUALLY HAPPENS IS THAT THE LEAD AGENCY (THE ONE CONTACTED FIRST) SOLICITS COOPERATIVE ASSISTANCE FROM OTHER AGENCIES AND GROUPS IN THE COMMUNITY TO HELP MEET CLIENT HEALTH CARE NEEDS. THIS APPROACH DOES NOT ADEQUATELY PROVIDE CARE FOR THOSE INDIVIDUALS WHO ARE NOT COVERED BY INSURANCES.

SOLUTIONS

THE BOTTOM LINE IS THIS, WE NEED A HEALTH CARE SYSTEM; AND A SYSTEM THAT WORKS.

WE SUGGEST TWO APPROACHES. FIRST, FUNDS FOR EMERGENCY HEALTH CARE SHOULD BE PROVIDED THROUGH THE FEDERAL EMERGENCY MANAGEMENT AGENCY (FEMA) TO HELP LOCAL AGENCIES PROVIDE HEALTH ASSISTANCE FOR THE HOMELESS, THE UNEMPLOYED, THE UNINSURED, THE UNDERINSURED AND THOSE WHO WILL BE UNEMPLOYED RESULTING FROM G.M. PLANT CLOSINGS. PRESENTLY, FEMA PROVIDES EMERGENCY ASSISTANCE FOR FOOD AND SHELTER SO WHY NOT INCLUDE EMERGENCY HEALTH ASSISTANCE. SECONDLY, WE NEED TO BE MOVING TOWARD A NATIONAL HEALTH CARE STRATEGY AND TOWARD DEVELOPING A NATIONAL HEALTH CARE SYSTEM FOR ALL OUR CITIZENS, WE OWE IT TO OURSELVES.

THANK YOU.

STATEMENT OF GAIL POTTER, ADMINISTRATIVE ASSISTANT,
HUMAN DEVELOPMENT COMMISSION

I am Gail Potter, Administrative Assistant for Mary Ann Vandemark, Human Development Commission, which is the Community Action Action Agency for the Thumb Area.

I would speak in favor of Bill# 177.

One of the main objectives of a community action agency is to promote self-sufficiency. We see so many people who are unemployed or living at or below the poverty threshold. These people definitely have a lack of access to health care.

The way the system is now we encourage those people to stay on Public Assistance. That way, their health care needs are taken care of. A parent with small children who wants to support them could lose health care assistance by taking a job of a forty (40) hour a week position at minimum wage.

We seem to be contradicting ourselves by saying on one hand - be self-sufficient but if they try there is nothing to help them along the way. They feel they are further ahead to stay entirely on public assistance.

Bill #177 will help these people and provide a way for them to receive health care and allow us to really help them to help themselves -- Thank you.

STATEMENT OF JAMES S. RICHARDSON, EXECUTIVE DIRECTOR, FLINT COMMUNITY PLANNED PARENTHOOD ASSOCIATION

My name is James S. Richardson. I am the Executive Director of Flint Community Planned Parenthood Association, 310 East Third Street, Flint, MI 48502.

I am very pleased that you have invited me to present my thoughts and information on health care issues in our community as they relate to the uninsured and underinsured.

To begin, I want to reinforce with you the importance of Title X and the federal support for family planning. Title X has enabled organizations such as ours and local health departments to provide reproductive health care to any person, regardless of income or whether or not they have health insurance.

In the Genesee County and Shiawassee areas, we have been able to serve over 9,000 patients per year--with 45% under 19 years of age and 25% under 17 years of age. These 9,000 patients visited our facilities an average of 3.4 times per year for a total of 30,815 visits. These patients have received what I believe is very high health care and the supplies they need for birth control.

Even though this is a record that gives us pride, we feel we have just begun to meet the need. We believe that we could have an even larger impact upon the community if we had the resources to expand. The need for expansion is evidenced by a teen birth rate where 15.5% of the babies born in 1985 were to teens. About 18% of the population receive public assistance and we are anticipating that the need will increase with the increase in job loss due to the economic reajustments.

A major problem faced when considering the need for health insurance of the uninsured/underinsured is determining the number of persons who are not covered in some manner. There are those who claim that with medicaid, medicare and private health insurers, all most all persons are covered and that the issue is not important.

Yet, I have a different sense of the need. I believe that there is a growing number of persons who are not covered by insurance. Unfortunately, I do not have the statistics to support this observation. All I have are indicators.

One indicator comes from the population that use our Planned Parenthood clinic. Under Title X rules, we are required to bill Medicaid for services for those persons who qualify. Even though most of our population is low income, just 13% are covered by medicaid.

A substancial number of our clients are single without children. Most all are without health insurance. (Those with insurance tend to receive services from private physicians and their birth control medication is paid by the insurance company.)

Our non medicaid clients are either employed in low wage service positions or are receiving general assistance. Those receiving general assistance can get their medical expenses covered by the State, but after the client proceeds through a complicated maze of first receiving permission from social services to seek medical help, second seeing a doctor/clinic, then returning to social services to receive permission to get medication. They have to follow this procedure each time they need to see a doctor or receive a refill of a prescription.

Those who are employed in low wage jobs or on part time jobs are usually not receiving any type of health insurance coverage. It is this population combined with those on general assistance who are probably using our services the most. It is this population that would benefit from a health insurance program.

I also feel that the lack of medical insurance for those in low wage and part time employment keeps women on public assistance when we know many of these women would rather work. I believe if I was receiving public assistance and I was faced with the choice of either working a low wage job and receiving no health coverage, that I would choose to stay on the public assistance. I feel that would be the responsible decision for my family.

I am of the opinion that if medicaid could continue for a women who is employed, that we would enable many women to enter the work force. I also believe that the cost of the insurance should not be completely born by the tax payer, but should be spread to an employer as well.

If you would indulge me, I would like to make one comment to you about this administrations support of health care on the international level.

We are very concerned about this administrations so called Mexico City Policy. Under this policy, the administration has blocked the U.S. Agency for International Development from providing family planning funds to countries where abortions are legally conducted or even offered as an alternative. The result of this policy has been the very high incidences of illegal and self-induced abortion, resulting in the maternal deaths which are estimated to range from 86,000 to hundreds of thousands each year.

We belive the policies to be arbitrary and capricious and that it contradicts congressional statues, the constitution, our international treaty obligations, medical ethnics and common sense.

I believe under the present budgetary process, there is an attmept to legislate this administrative policy. I hope you will be mindful of those who would attempt to attach admendments to the budget that would implement this policy. I hope you will oppose any such amendments.

Thank you very much for this opportunity to come before you.

STATEMENT OF GERALD SCHUSTER, RABBI, TEMPLE BETH EL,

FLINT, MI

My name is Gerald Schuster. I am Rabbi of Temple Beth El in Flint, Coordinator of Pastoral Care Services at Hurley Medical Center, and Chairperson of The Urban Coalition Sub-Committee on Health and Welfare.

In the past ten years I have been witness to the erosion of health care services, especially for the underemployed who have no medical insurance coverage and whose incomes do not qualify them for medicaid and for the many elderly and retired people who have inadequate, or no coverage.

With an economic crisis hovering over Flint, more and more people will fall through the medical care cracks. More and more people who will accept lesser employment in order to insure their basic survival will find themselves without any medical insurance and also find that because of their employment they are not eligible for assistance to meet health needs.

In many instances, people who do find treatment will be unable to pay for the medication and will not be able to have prescriptions filled because they are too costly. I know of people who hesitate going to clinics that subvent their visits, because they know that in no way can they pay for the medication.

The crisis in the automobile industry, will soon result in a significantly greater percentage of the citizens of Flint who will be unable to obtain proper medical care. This crisis will result in the medical disenfranchisement of more and more of the members of our community.

I believe that basic health care is the right of everyone in our nation. With narrowing resources for health care, a basic standard of health care remains an ethical matter and an issue of distributive justice.

It is a blight on the character of our nation and a scandal of the first order that our national leadership, including the members of congress, are heavy on rhetoric and light on deed. I sincerely hope, Senator Riegle, that you will become a leader in addressing the health needs of our community and nation.

STATEMENT OF GERALD SELKE, ADMINISTRATOR,
FLINT OSTEOPATHIC HOSPITAL

GOOD MORNING, I AM GERALD SELKE, ADMINISTRATOR AT FLINT OSTEOPATHIC HOSPITAL. I AM PLEASED TO BE HERE TODAY TO DISCUSS THE PROBLEMS OF ACCESS TO CARE FOR THE UNINSURED AND UNDERINSURED.

CARE FOR THE MEDICALLY INDIGENT IS A SOCIAL PROBLEM THAT IS REACHING CRISIS PROPORTIONS. THE NUMBER OF THOSE INDIVIDUALS WITHOUT HEALTH CARE COVERAGE IS GROWING AT AN ALARMING RATE. NATIONALLY, APPROXIMATELY 15 PERCENT OF THE POPULATION HAS NO PRIVATE HEALTH INSURANCE AND ARE INELIGIBLE FOR GOVERNMENT PROGRAMS. TWO-THIRDS OF THESE PEOPLE ARE "WORKING POOR" WITH NO HEALTH INSURANCE AS A FRINGE BENEFIT. THE REST ARE NOT IN THE WORK FORCE BUT DON'T MEET THE ELIGIBILITY REQUIREMENTS FOR GOVERNMENT PROGRAMS LIKE MEDICAID.

THE HOSPITAL MISSION HAS HISTORICALLY INCLUDED PROVIDING NEEDED HEALTH CARE SERVICES TO THOSE PATIENTS UNABLE TO PAY THE COSTS. TODAY, HOSPITALS ARE DELIVERING MILLIONS OF DOLLARS WORTH OF CARE AND ARE RECEIVING LITTLE OR NO COMPENSATION FOR IT. IN 1981, MICHIGAN HOSPITALS SPENT $112 MILLION FOR CHARITY CARE. THIS NEARLY DOUBLED IN 1984 TO $214 MILLION. BETWEEN 1980 AND 1984, THE AMOUNT OF UNCOMPENSATED CARE AS A PERCENTAGE OF GROSS PATIENT REVENUES INCREASED FROM 2.16 TO 2.98 PERCENT. IN FLINT, HOSPITALS DELIVERED $9 MILLION OF FREE CARE IN 1986.

WHAT'S CHANGED TO TRIGGER THE SO CALLED "EMERGING CRISIS OF OUR TIME?" A NUMBER OF THINGS. MEDICARE AND OTHER GOVERNMENT PROGRAMS ARE FACING MAJOR CUTBACKS AND ADDITIONAL RESTRICTIONS

THAT EFFECTIVELY ELIMINATE COVERAGE FOR MUCH OF THE INDIGENT NEEDING CARE. MEDICAID HAS ALREADY ERODED TO THE POINT WHERE ONLY 40 PERCENT OF THE NATION'S POOR IS ELIGIBLE.

EMPLOYERS AND INSURERS ARE UNWILLING TO CONTINUE THE INDIRECT FUNDING OF UNCOMPENSATED CARE. CHARGES ARE BEING SCRUTINIZED FOR THE SERVICES ACTUALLY RENDERED WITHOUT CONSIDERATION FOR CHARITY CARE.

WITH THE EMPLOYMENT SHIFT FROM MANUFACTURING TO SERVICE SECTORS AND FROM FULL TO PART-TIME EMPLOYMENT, PRIVATE HEALTH INSURANCE COVERAGE HAS REDUCED IN BOTH QUANTITY AND SCOPE OF COVERAGE.

LEGITIMATE HEALTH NEEDS ARE BEING UNMET OR DEFERRED BECAUSE THE BARRIERS ARE SHRINKING ACCESS TO MEDICAL CARE AND THE CAPACITY OF OUR HEALTH CARE SYSTEM. THE HOSPITAL INDUSTRY HAS REACHED THE CROSSROADS OF AN IMPORTANT SOCIAL RESPONSIBILITY. ALTHOUGH HOSPITALS REMAIN DEDICATED TO PROVIDING QUALITY CARE WITH ACCESS FOR ALL -- INCLUDING THE MEDICALLY INDIGENT -- DOING SO THREATENS THE SYSTEM'S SURVIVAL. SOLUTIONS MUST BE FOUND THAT WILL ENSURE NEEDED ACCESS TO HEALTH CARE FOR EVERYONE, REGARDLESS OF THEIR ABILITY TO PAY.

IN FLINT, WE SEE THE NEED FOR PROGRAMS TO THIS PROBLEM AS THE LOCAL ECONOMY CONTINUES TO ERODE. GENESEE COUNTY HAS 47,000 ON PUBLIC ASSISTANCE. ACCORDING TO THE LEAGUE OF HUMAN RESOURCES, THE AVERAGE WELFARE RECIPIENT IN MICHIGAN IS RECEIVING 67 PERCENT OF POVERTY LEVEL SUBSISTENCE. NINETY (90) PERCENT OF THOSE ON PUBLIC ASSISTANCE ARE WOMEN AND CHILDREN, POTENTIALLY A MORE VULNERABLE GROUP.

THESE TRENDS ARE LEADING, INEVITABLY, TO A CRISIS IN CARE FOR THE MEDICALLY INDIGENT. NO SINGLE COURSE OF ACTION WILL BE EITHER APPROPRIATE OR SUFFICIENT. A COMBINATION OF ACTIONS MUST BE TAKEN TO ADDRESS THE CAUSES OF THE IMPENDING CRISIS.

THE PRIVATE SECTOR CAN TAKE ACTION TO MAKE AFFORDABLE PRIVATE INSURANCE MORE AVAILABLE AND REDUCE THE NUMBER OF PERSONS WITHOUT HEALTH INSURANCE. THESE ACTIONS CAN, AND SHOULD BE, SUPPORTED BY GOVERNMENT POLICIES THAT ENCOURAGE INDIVIDUALS AND EMPLOYERS TO OFFER HEALTH INSURANCE AS AN EMPLOYEE BENEFIT AND EXTEND COVERAGE TO ALL MEMBERS OF AN EMPLOYEE'S FAMILY. GOVERNMENT CAN ALSO ENCOURAGE AND SUPPORT THE EFFORTS OF PRIVATE INSURERS TO DEVELOP METHODS OF EXTENDING PRIVATE INSURANCE COVERAGE TO THE MEDICALLY UNINSURABLE AND THOSE WHO ARE UNABLE TO PURCHASE INSURANCE THROUGH THEIR EMPLOYERS.

ALTHOUGH EXPANDING THE AVAILABILITY OF PRIVATE INSURANCE IS IMPORTANT, A SIGNIFICANT NUMBER OF INDIVIDUALS WILL ALWAYS BE UNINSURED AND WILL NEED DIRECT PUBLIC ASSISTANCE. IN THE LONG TERM, THE MOST EFFECTIVE METHOD OF PROVIDING THIS ASSISTANCE IS THROUGH THE RESTRUCTURING AND STRENGTHENING OF MEDICAID. STRUCTURALLY, THE MEDICAID PROGRAM SHOULD BE REORGANIZED INTO THREE DISTINCT PROGRAMS. EACH OF THE PROGRAM'S COMPONENTS -- SUPPLEMENTAL ACUTE CARE COVERAGE AND LONG TERM CARE COVERAGE FOR MEDICARE BENEFICIARIES, AND ACUTE CARE COVERAGE FOR THE NON-MEDICARE POOR PRESENT UNIQUE PROBLEMS THAT WOULD BE BETTER ADDRESSED THROUGH SEPARATE PROGRAMS. FINANCIALLY, A STABLE SOURCE OF FUNDING THAT BROADLY AND EQUITABLY DISTRIBUTES THE COST OF THE PROGRAMS ACROSS ALL AMERICANS SHOULD BE IDENTIFIED AND PUT IN PLACE.

THESE REFORMS WILL NOT BE PUT IN PLACE OVERNIGHT. UNTIL THEY, OR COMPARABLE MEASURES, HAVE BEEN INSTITUTED, THERE WILL CONTINUE TO BE A ROLE FOR OTHER STATE AND LOCAL GOVERNMENT PROGRAMS, AS WELL AS A NEED FOR CONTINUED RELIANCE ON PRIVATE INSURERS TO SUBSIDIZE THE CARE PROVIDED TO PATIENTS WHO DO NOT RECEIVE GOVERNMENTAL ASSISTANCE.

I WOULD ENCOURAGE YOU, SENATOR RIEGLE TO:

A) OPPOSE ANY EFFORTS TO REDUCE SUPPORT OR RESTRICT ELIGIBILITY FOR MEDICAID.

B) SUPPORT EFFORTS TO RESTRUCTURE MEDICAID TO INCREASE ITS COVERAGE OF THE POOR WHO ARE NOT ALSO ELIGIBLE FOR MEDICARE.

C) SUPPORT EFFORTS TO INCREASE THE NUMBERS OF PEOPLE COVERED BY PRIVATE HEALTH INSURANCE THROUGH RISK POOLS FOR THE MEDICALLY UNINSURABLE, IMPROVED CONTINUATION COVERAGE OF LAID OFF WORKERS AND TAX INCENTIVES OR OTHER MEASURES THAT PROMOTE COVERAGE OF DEPENDENTS, THE SELF-EMPLOYED AND EMPLOYEES OF SMALL FIRMS.

D) SUPPORT EFFORTS TO ESTABLISH A MINIMUM, LEVEL OF GOVERNMENT MANDATED EMPLOYEE HEALTH BENEFITS.

302 Kensington
Flint, Michigan 48502

Phone 313-762-8000

St. Joseph Hospital

TO: U.S. Senator Donald Riegle

FROM: Ann H. Harris, ACSW, Director of Social Work
St. Joseph Hospital

DATE: June 22, 1987

RE: Health Care for the Uninsured and Underinsured

I. Older Persons

A. Medication

Older persons with chronic health problems who have no insurance for prescription coverage are spending as much as $100 a month for medications. We receive between five and ten calls or referrals per month from persons who cannot afford to fill prescriptions. The Red Cross Community Services Program will assist, but only on a temporary rather than a long-term basis and for some of these persons, the problem will occur monthly. We refer to Department of Social Services for Medicaid or Medicaid spend down, but the spend down program is confusing to people and they must report their medical-related bills on a regular basis and reapply every six months. This is difficult for older persons who have trouble understanding the procedures, mobility problems, or transportation problems. It is also difficult for some older persons to accept "welfare" and they will make sacrifices in other areas instead.

B. Medicare Deductibles

Older persons who have Medicare only are running into difficulty with the increase in deductibles, out-of-pocket charges that increase each year.

C. Nursing Homes

Older persons who are in need of nursing home placements and their families are surprised to learn that Medicare only covers skilled care and only for a limited time. More education needs to be provided for Medicare recipients and also for the younger population to plan for their own futures regarding the limitations of Medicare. Also, over the years Medicare has "tightened

up" on the definition of skilled care so that a nursing home resident ten years ago who was considered skilled is now determined to be basic. Older persons and their families are not apt to appeal decisions either, because they do not know that they can, do not have someone to assist them with it, or do not want to "rock the boat".

Another problem is the older married couple where one needs nursing home placement and is Medicaid eligible, the spouse at home is left with only approximately $370 to live on, causing undue hardship. It is also more difficult to find nursing home placements for Medicaid patients, as they pay a lower rate. Nursing homes can only afford to accept a certain percentage of Medicaid residents in order to stay in business.

II. Persons Age 18 - 65

This has become an increasing problem in the Flint area over the past six years, as GM has been employing fewer persons and increasing layoffs, and the problem is growing with more anticipated layoffs. In the past, most people in this area had coverage and it was usually pretty complete. Now we find more persons working with no insurance benefits provided or less comprehensive coverage. To address this problem, in 1980 we began a program for pregnant women who had no insurance or limited insurance and not Medicaid eligible for prenatal and postnatal care, which has been highly successful. This serves primarily young married couples who are working but have no insurance benefits (some will become eligible for insurance after they have worked longer). We currently have 60+ women enrolled.

For persons between the ages of 18 and 65 who are hospitalized with no insurance, they must be disabled to qualify for Medicaid. Most are not, but required hospitalization for an acute medical problem. They may qualify for County Hospitalization, but funds are limited. For outpatient care, the community has some free clinics or clinics where discounts are available, and the Red Cross program will cover some outpatient testing if persons are not Medicaid eligible, but no long-term assistance. These persons tend to not seek care until it becomes more serious or just stop taking medications before they should because they cannot afford the refills.

In summary, problems of uninsured or underinsured persons needing medical care in this area is increasing and will continue to increase as more working persons do not have insurance benefits and as the elderly population grows. Although the community is attempting to address these problems through various task forces and programs, we will not be able to meet all of these needs in the future.

AHH/vsb

STATEMENT OF VALLEY AREA AGENCY ON AGING

On behalf of our region's older citizens, the Valley Area Agency on Aging wishes to draw your attention to gaps in the health insurance coverage for the elderly. We will be addressing three issues:

1. Fraud in the sale of "Medigap" policies;

2. Medicaid spend-down; and

3. Long-term care insurance.

The gaps in Medicare coverage are extensive. Prescription drugs can constitute a very high expense for the chronically ill person. High hospital deductibles and co-pays exhaust the resources of many elderly.

There are some good private "Medigap" policies available at reasonable prices. Unfortunately, there is also fraud perpetrated in selling elderly persons so-called "Medigap" policies which duplicate Medicare benefits, resulting in wasted premiums for benefits which are never paid. Therefore, we urge you to consider more stringent government regulation of Medigap policies.

For the older person of limited means who is not part of a retiree group, the premium for a Medigap policy may be prohibitive. These near poor must rely on the Medicaid "spend-down" after they have nearly exhausted their own personal resources. The Medicaid spend-down system requires that the near poor individual reapply for Medicaid every six months, an extremely cumbersome process which causes some older persons to stop applying, even though they qualify and do need the assistance.

The Medicaid spend-down system imposes a severe hardship by requiring the applicant to incur bills amounting to the full spend-down amount for a six-month period before receiving any assistance from Medicaid. In other words, if the person's income exceeds Medicaid guidelines by $10.00 per month, that individual must submit $60.00 worth of bills before they can receive Medicaid. It is not unusual for prescription drugs alone to cost an older person $60.00 per month; however, that person whose income is only $10.00 per month over the guideline doesn't have $60.00 to purchase their medicine in the first month.

We recommend an overhaul of the Medicaid spend-down to allow the near poor to pay a monthly co-pay proportionate to their income. Such a revision would also assist the working poor who do not have health insurance.

A major gap in our country's public and private insurance system is the lack of coverage for long-term care. We define long-term care as extended basic care in a nursing home or at home. Coverage for this contingency is non-existent except under Medicaid, which requires impoverishment of patient and spouse to qualify. Even Medicaid coverage is limited and encourages institutionalization by not covering services in the home.

The danger of a family exhausting their life savings if faced with the need for long-term care is exacerbated by many people holding the erroneous belief that their Medicare and Medigap policies cover long-term care. The reality that many families in this situation do experience impoverishment is demonstrated by the fact that 44% of nursing home costs are paid by Medicaid. With the exception of Congressman Pepper's HR 65, the proposals for catastrophic coverage under Medicare which have recently been introduced do not address long-term care.

The few private long-term care policies currently available are marketed to high risk populations at prices prohibitive to all but the very wealthy; however, the formation of very large groups of age 55 and up results in an actuarially sound policy at a reasonable premium which is just beginning to be explored by the private sector. If groups of adults begin to purchase long-term care insurance from the beginning of their working lives, it is estimated that the premiums would amount to .05% of wages. Thus, we content that is feasible to add long-term care coverage to Medicare through lifetime payroll withholding.

We urge you to recognize the importance of long-term care coverage in your deliberations regarding health insurance.

JA:sg

STATEMENT OF CHARLES C. WILLIAMS, DIRECTOR, DEPARTMENT OF SOCIAL SERVICES, GENESEE COUNTY

SENATOR REIGLE AND MEMBERS OF THE HEARING PANEL, I WOULD LIKE TO THANK YOU FOR PROVIDING ME THE OPPORTUNITY TO SPEAK TO THE ISSUE OF HEALTH CARE ACCESS AS IT RELATES TO LARGE NUMBERS OF OUR STATE AND LOCAL POPULATIONS.

AS DIRECTOR OF GENESEE COUNTY DEPARTMENT OF SOCIAL SERVICES, MY EXPERIENCE IS WITH THE LOW-INCOME POPULATION WHOSE MAJOR, PRIMARY NEEDS INCLUDE THE ACQUISITION OF ADEQUATE HEALTH CARE. TWO PROGRAMS, MEDICARE AND MEDICAID, ENACTED IN THE NINETEEN SIXTIES PROVIDE THE MAJOR SOURCE FOR HEALTH CARE AMONG THE ELDERLY AND LOW-INCOME POPULATIONS. MEDICARE, A FEDERALLY-FUNDED PLAN, IS ADMINISTERED BY THE SOCIAL SECURITY ADMINISTRATION. MEDICAID IS STATE-FUNDED AND ADMINISTERED BY THE MICHIGAN DEPARTMENT OF SOCIAL SERVICES. MEDICAID PROVIDES COVERAGE FOR RECIPIENTS OF AID TO DEPENDENT CHILDREN, SUPPLEMENTAL SECURITY INCOME (SSI), AND ANYONE WHO IS FINANCIALLY NEEDY AND UNDER AGE 21, PREGNANT, AGE 65 OR OLDER, BLIND, OR DISABLED. AN INDIVIDUAL MAY RECEIVE BOTH MEDICAID AND MEDICARE, IN WHICH CASE BENEFITS ARE COORDINATED. NATIONWIDE, THE MEDICARE PROGRAM FINANCES HEALTH CARE COSTS FOR SOME 30-MILLION ELDERLY AND DISABLED PERSONS. THE ESCALATING COSTS FOR THESE SERVICES HAS BEEN WELL-DOCUMENTED AND COST CONTAINMENT PROGRAMS INITIATED TO CURB SPIRALING COSTS. IT IS NOT MY INTENT TO DEAL WITH THE COSTS OF HEALTH SERVICES, HOWEVER. THE COST FACTOR IS A PERTINENT CONSIDERATION IN ANY MOVE TO EXTEND HEALTH CARE BENEFITS TO SOME 15-MILLION INDIVIDUALS WHO HAVE INADEQUATE COVERAGE. OUR FOCUS HERE IS ON SOLUTIONS OR POSSIBILITIES THAT CAN LEAD TOWARD REDUCING THIS CRITICAL PROBLEM. ONE EFFORT BY THE MICHIGAN DEPARTMENT OF SOCIAL SERVICES WILL BE IMPLEMENTED SHORTLY AS A DEMONSTRATION PROJECT CALLED, "MICHIGAN HEALTH CARE ACCESS PROJECT."

THE ROBERT WOOD JOHNSON FOUNDATION, UNDER ITS HEALTH CARE FOR THE UNINSURED PROGRAM, AWARDED A GRANT TO INTIATE A PILOT PROJECT TO IMPROVE HEALTH CARE ACCESS FOR RECIPIENTS OF PUBLIC ASSISTANCE. GENERAL ASSISTANCE (GA) AND AID TO DEPENDENT CHILDREN RECIPIENTS ENTERING THE WORKFORCE ON JOBS PROVIDING NO HEALTH INSURANCE WOULD BE TARGETED. THE PROGRAM WILL ALSO OFFER HEALTH BENEFITS FOR EMPLOYED, LOW-INCOME PERSONS WHO CANNOT QUALIFY FOR MEDICAID OR GA, AND FOR PERSONS ON GA. THE MICHIGAN LEAGUE OF HUMAN SERVICES WAS AWARDED THE GRANT, SERVING AS THE APPLICANT AGENCY FOR ELEVEN OTHER AGENCIES.

THE DEMONSTRATION PROGRAM WOULD SELECT THREE COUNTIES, SMALL, MEDIUM, AND LARGE, IN WHICH TO LAUNCH THE PROJECT. THE FUNDING FOR THE PROGRAM, WHICH IS UNIQUE, WILL COMBINE THE EXISTING COUNTY-FUNDED RESIDENT COUNTY HOSPITALIZATION WITH STATE FUNDS FROM THE GA MEDICAL PROGRAM. THESE TWO REVENUES WILL PROVIDE A COMPREHENSIVE INPATIENT HOSPITAL AND AMBULATORY BENEFIT PLAN. RCH COUNTY FUNDS, EXISTING GA MEDICAL STATE FUNDS, AND A SPECIAL $500,000 APPROPRIATION FOR THE PROJECT INCLUDED IN THE MICHIGAN DEPARTMENT OF SOCIAL SERVICES BUDGET WILL PROVIDE SERVICES. ALSO CONTRIBUTING TO THE PROGRAM COSTS WILL BE PREMIUMS PAID BY PARTICIPATING EMPLOYEES NO LONGER ON ASSISTANCE AND THEIR EMPLOYER. ADMINISTRATIVE COSTS WILL BE MET FROM FOUNDATION FUNDS. SELECTED COUNTIES WILL ALL UTILIZE THE SAME FUNDING STRUCTURE.

I AM PLEASED TO ANNOUNCE THAT GENESEE COUNTY WAS SELECTED FOR A PILOT SITE ALONG WITH MARQUETTE AND DELTA COUNTIES. THE SELECTION RESULTS WERE MADE KNOWN DURING THE FIRST WEEK OF JUNE 1987, AND PLANNING TOWARDS IMPLEMENTATION IS UNDERWAY. IN GENESEE COUNTY, THE C.S. MOTT FOUNDATION IS CONSIDERING A SPECIAL GRANT TO ASSIST IN THE PROJECT. FOUR OF THE MAJOR LOCAL HOSPITALS, MC LAREN, HURLEY MEDICAL CENTER, ST. JOSEPH, AND FLINT OSTEOPATHIC, HAVE AGREED TO A TWENTY PERCENT DISCOUNT IN MEDICAID RATES.

THE BASIC OBJECTIVES OF THE HEALTH CARE ACCESS PROJECT ARE:

1. IMPROVE ACCESS TO HEALTH CARE COVERAGE FOR PERSONS RECEIVING GENERAL ASSISTANCE (GA):
2. EXTEND COVERAGE TO PERSONS WHO MOVE OFF GA AND JOIN THE RANKS OF THE LOW INCOME WORKING UNINSURED:
3. EXTEND COVERAGE TO PERSONS WHO LEAVE AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC) FOR LOW WAGE EMPLOYMENT AND BECOME UNINSURED WHEN THEY EXHAUST THEIR MEDICAID EXTENSION:
4. OFFER COVERAGE TO THE LOW WAGE WORKING UNINSURED DENIED MEDICAID BECAUSE THEY ARE CATEGORICALLY INELIGIBLE;
5. DEVELOP A ONE-THIRD SHARE PLAN TO SPREAD THE COST OF COVERING THE WORKING UNINSURED IDENTIFIED IN (2), (3), and (4) ABOVE AMONG EMPLOYEES, EMPLOYERS, AND A STATE/COUNTY FUNDED LAST RESORT FUND;
6. CONTRACT WITH SELECTED PROVIDERS TO DELIVER CASE-MANAGED CARE IN AN HMO, PRE-PAID CAPITATION PLAN. PREFERRED PROVIDER ORGANIZATION AND/OR ON A FEE FOR SERVICE MANAGED CARE BASIS TO THE TARGETED POPULATION.

IN 1986, 761 INDIVIDUALS LEFT ADC DUE TO EMPLOYMENT AND 511 GA RECIPIENTS FOUND JOBS AND LEFT PUBLIC ASSISTANCE. IT IS PROJECTED THAT OF THOSE RETURNING TO PUBLIC ASSISTANCE 80% WILL HAVE HELD JOBS WITH NO HEALTH INSURANCE COVERAGE.

ALSO, THE PROJECT INTENDS TO MEASURE THE EXTENT TO WHICH THE FOLLOWING CAN BE ACHIEVED.

1. THE EXTENT TO WHICH SMALL, PERHAPS MARGINAL EMPLOYERS NOT CARRYING HEALTH INSURANCE WILL VOLUNTARILY BUY INTO A SYSTEM IF THE COST IS FIXED AT A MORE AFFORDABLE RATE THAN OF COMMERCIAL CARRIERS;
2. THE EXTENT TO WHICH LOW INCOME WAGE EARNERS CAN AFFORD AND WILL ELECT TO BUY INTO A SYSTEM WHICH OFFERS CASE-MANAGED CARE FROM A LOW COST LIMITED PROVIDER NETWORK IN BOTH AN URBAN AND A RURAL SETTING;
3. THE WILLINGNESS OF A PROVIDER NETWORK TO SERVE THE LARGEST POPULATION AT A RELATIVELY LOW FIXED RATE;
4. THE DEGREE OF LOCAL SUPPORT FOR AN APPROACH SUCH AS THE ONE-THIRD SHARE PLAN;
5. THE EXTENT TO WHICH GA RECIPIENTS BECOME AND STAY EMPLOYED WHEN HEALTH CARE COVERAGE IS AVAILABLE WHEN THEY LEAVE PUBLIC ASSISTANCE, AND THE EXTENT OF STATE SAVINGS IN PUBLIC ASSISTANCE CASH GRANTS ATTRIBUTABLE TO PERSONS MOVING INTO THE PAID LABOR FORCE.

CATASTROPHIC AND LONG-TERM HEALTH CARE

MONDAY, JUNE 29, 1987

U.S. SENATE,
COMMITTEE ON THE BUDGET,
Lansing, MI.

The committee met, pursuant to notice, at 10 a.m., in Prudden Hall at the Lansing Civic Center, 505 West Allegan, Lansing, MI. Hon. Donald W. Riegle, Jr., presiding.

Present: Senator Riegle.

Staff present: Joan Huffer, legislative assistant to Senator Riegle.

Senator RIEGLE. This committee hearing will come to order. I want to welcome all of you that are here this morning and I want to make sure that the acoustics are right in this room so that we're all able to hear. So I'm going to talk at about this level for now. If you can't hear, raise your hand. I guess if you can't hear, you don't know that I'm asking you to raise your hand. [Laughter.] In any event, it looks like we're all able to hear and as I say, I'm very pleased to have all of you in attendance. There will be more people coming as the morning goes along. I want to thank the city of Lansing for providing parking.

This is an official hearing of the Senate Budget Committee on the subject of catastrophic health care needs for our senior citizens. We have a number of important witnesses that have agreed to speak. They are down in front. And we will call on them after I make some opening comments on the state of the health care crisis for senior citizens in this country. After the witnesses have spoken, those with prepared testimony, we're going to invite anyone in the audience who wishes to give a statement to do so. And I want to encourage anybody who has observations to make, to take this occasion to say them. You don't have to feel nervous about doing so. I don't think you should feel as if you have to have prepared notes. But if you're aware of aspects of this problem that you think we need to hear and that we need to consider in drafting legislation at the Federal level, then today is the time to share those thoughts so we can have some democracy in action and we can have your input on this critical matter.

Now, before I go into the discussion of some key background facts that will relate to this hearing today, we have two special guests who are in attendance and are just going to make a brief comment. The first is State Senator Mitch Irwin seated to my left. Mitch, we're delighted to have you. Mitch is going to testify later so we're delighted that he is here. The Mayor of Lansing, Mayor McCain, is here as well. Mayor.

REMARKS OF MAYOR McCAIN

Mayor McCain. Good morning. I'd just like to welcome you to the Civic Center and to the city of Lansing, your capital. I see a number of friends in the audience, members of the same church that I am. It's good to see so many of you here today. I welcome you not only as Mayor but also as a member of the Administrative Board of the Aging Consortium and past chairperson of that board. As I sat through meetings of that Aging Consortium administrative board for the last five and a half years, it has become more and more apparent to me that health care for seniors is a very, very serious problem. And it has also become clear to me as the city of Lansing and the State Office on Aging have worked so cooperatively together under Libby Maynard's able leadership, that we really need a change in the basic system. And so I am here today and am very interested in the outcome of this hearing. I'll stay as long as my schedule will allow as I am most interested in hearing your testimony. Thank you. [Applause.]

Senator Riegle. Thank you Mayor McCain.

OPENING STATEMENT OF SENATOR RIEGLE

Now let me share with you some background facts as to where we are and then we'll go to our witnesses. The problem of catastrophic health problems arising late in life have become a crisis, I think, here in America and for an increasing number of American people. A senior citizen can get hit with a major illness and can find that after their Medicare coverage has been exhausted and other coverage that they may have had been exhausted, that their whole lifetime savings could be wiped out with just one illness. And more and more of our seniors are living constantly with that fear, because their incomes are low and with the cost of health care and the cost of prescription drugs can be great. This situation cries out for some new answers.

Last year we spent $74 billion on Medicare coverage in our country and yet as most of you know there are many gaps in Medicare coverage. The current situation has got to be changed and we have legislation now pending in the United States Senate to deal with that problem. Now President Reagan has come forward with a proposal to provide some catastrohic health insurance coverage in certain instances. And it is a step forward. I will show you in a minute on a chart how much of the problem that would cover because it just covers a part of it. Nevertheless, it's an important step and I think we should take every forward step that we can.

But President Reagan has said that the catastrophic health insurance program he wants to see enacetd has to be paid for directly by the people getting the coverage. In other words, the government would not provide any money; the additional coverage would have to be paid for by the beneficiaries themselves. Coverage would be broader than under the current Medicare system. Under the President's proposal, there would be a larger monthly premium that would be deducted from your social security payment, as the Medicare payment now is, to pay for this new catastrophic health coverage.

I would now like to outline two things that the Senate is now considering in its version of catastrophic health insurance. First, what benefits you could anticipate having under the new protections and then how it would be paid for. Under this proposal, the out-of-pocket costs to beneficiaries for all the services that Medicare would cover would be limited to a maximum of $1,700 a year. So that meant if you got very ill and were in the hospital for a long period of time getting intensive care, the most those bills could amount to in a given year would be $1,700. Similarly, no matter how many times you had to go to a doctor for medical treatment you would still not pay more than that total figure—$1,700 a year—and most people, of course, would pay less. Now that also means that it has to be a doctor that takes Medicare payments as payment in full.

The Senate proposal would also expand the coverage for skilled nursing home care, for home health care, and for hospice care although those coverages would be limited. We are working on trying to expand the proposal to cover drugs and medicines. They are not presently in the President's proposal but as you will hear today we have seniors that are spending $2, $3, $4 hundred per month on prescription drugs just to stay alive. Se we need some protection in that area as well because you could go broke paying for medicine today just as you can paying for a hospital room.

These new coverage benefits would be paid for as follows: As you know the basic Medicare monthly premium now is $17.90. It's automatically deducted from your Social Security payment if you are now collecting Social Security. That payment would go up by $4 a month to pay for this new catastrophic health care protection. So instead of having a deduction of $17.90 a month you would have a deduction of $21.90 a month. In addition to that there would be a second payment, because the $4 a month from everybody wouldn't be enough to pay for this coverage overall. This second, supplemental premium, would be based upon one's ability to pay.

Now many people today who are on Medicare also have private Medigap insurance. I would like to have a show of hands of how many of you here in the audience who are now on Social Security also have some form of a private Medigap insurance. Would you raise your hands please? [Audience complies with a show of hands.] So a very large number of you in the audience do. This new catastrophic health insurance under Medicare would be designed to replace a large part of that Medigap insurance. So for many of you—you would have to check the coverage carefully—but presumably you would be able to stop buying the private insurance which is generally more expensive and instead you would get this new coverage under Medicare by paying this higher $4 a month premium plus this supplemental payment.

The supplemental payment would be determined according to a sliding scale based on your annual income. Those with higher incomes would pay more in the way of supplemental premium; many with modest incomes or lower incomes would pay little or no supplemental premium at all. It would range up to $800 a year for that supplemental payment but that would be for someone who is in an income category of say above $100 thousand a year. But it's estimated that 60 percent of those who are now on Medicare would

not pay supplemental premium at all. In other words, the way it would phase in, 60 percent of the population would not pay any supplemental premium. Others would pay a small amount, maybe $20 a year, $60 a year, $100 a year, and in extreme cases, up to as much as $800 a year. But bear in mind again there would be an offset to this because presumably you could then stop buying the private Medigap insurance so you would have a saving there.

Now these proposals only deal in health care for acute illness or serious medical problems. And we have to keep that in mind. My father, for example, had a serious heart attack—he had 5 bypasses put in—that would constitute serious acute illness. It would not expand coverage for routine medical exams, or dental care or eyeglasses, or as the proposal is presently written, would not cover prescription drugs, although we are trying to broaden the coverage to include prescription drugs.

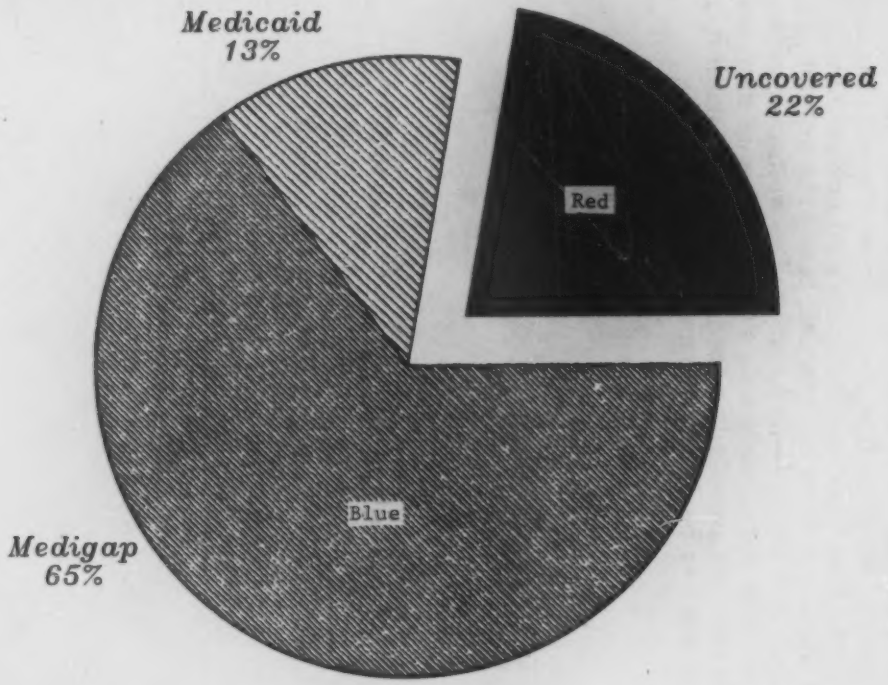
Beyond these serious, acute illnesses that strike there is another huge problem—I'll show it to you on the chart—that is the number of people who require long term heatlh care in a nursing home or at home. The majority of people who incur catastrophic expenses get into a situation of poor health late in life, which may not require a hospitalization that would be covered under this new insurance, but it could require going into a nursing home. Presently there is no coverage in that area, unless you exhaust all your assets and go on welfare and then you qualify for Medicaid and then Medicare will make a payment toward nursing home care. So even under this new catastrophic health insurance proposal, which covers a part of the problem, it still leaves a gigantic area that we are not yet addressing, namely long term nursing home care and long term home health care for a person who is bedridden and otherwise needs medical attention.

Nursing home care is very expensive, as you know. On the average last year, it cost about $22 thousand a year for 1 year in a nursing home. It can be higher, in some cases it's lower, but that's the average figure. It doesn't take long to exhaust a life time of savings at the rate of $22,000 a year and of course Medicare doesn't pay for that. I want to show you these charts and then we'll go to our first witnesses.

This first chart shows how catastrophic costs—defined as $2,000 or more out-of-pocket—for major acute illnesses such as heart attack, or stroke, that are not covered by Medicare are handled today. About 13 percent of these catastrophic bills are picked up by Medicaid. These are people who have exhausted all of their assets and have gone on welfare. About 65 percent of those bills are now paid by this extra Medigap insurance which many of you are now buying as you demonstrated by your show of hands. The Medigap policies, which can be quite expensive, are picking this portion of the expenses not covered by Medicare. Then there is this section

right here—this section in red. These are catastrophic costs being incurred by people, some in this room, where there's absolutely no coverage or protection whatsoever. There's no private health insurance beyond Medicare, such as is in this blue area (referring to Medigap coverage). The person may be above the welfare level, so they don't get any help from Medicaid, so all of this is now an area where people can just be totally wiped out. Without insurance protection, the assets can be drawn down until they're gone.

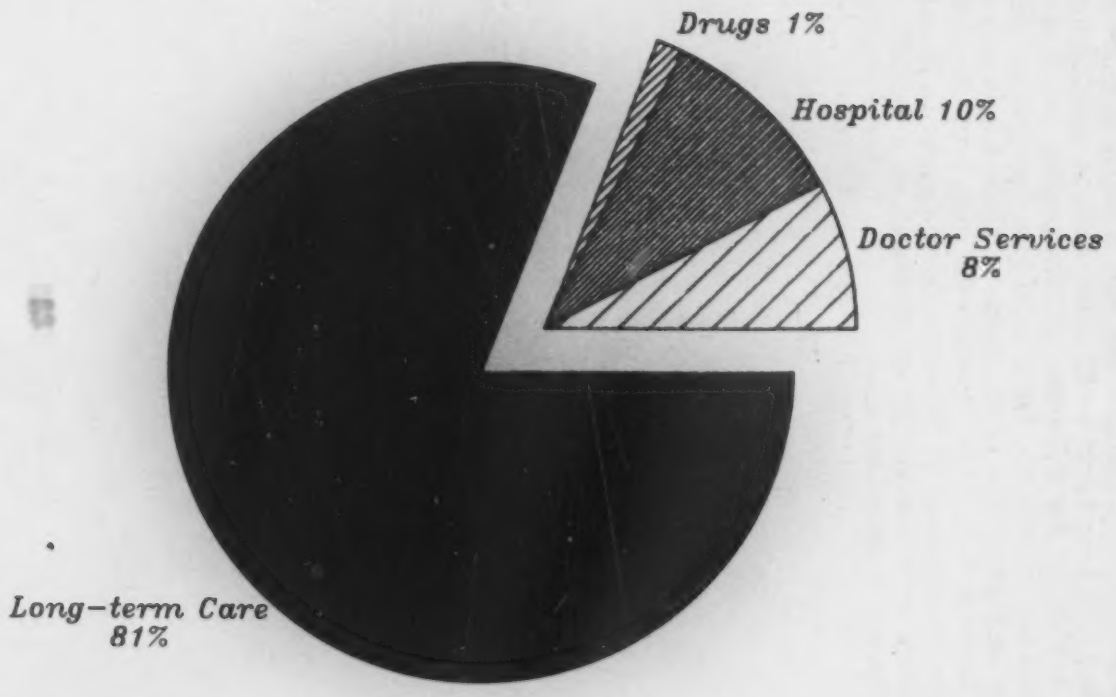
CATASTROPHIC HEALTH CARE COVERAGE FOR SENIOR CITIZENS



Office of Senator Donald W. Riegle, Jr.

This second chart includes not only a major sickness or acute illness, but also long term health care, such as nursing home care or home health, in the definition of catastrophic out-of-pocket health expenses for the elderly. Long term care today is actually generating far and away the lion's share of these kinds of expenses because there is very little coverage for long term care. Medigap insurance doesn't cover it, Medicare doesn't cover it. So unless you're in a situation where you go on Medicaid, as a welfare person, you don't get any help in this area.

CATASTROPHIC OUT–OF–POCKET EXPENSES OF THE ELDERLY



Office of Senator Donald W. Riegle, Jr.

Today we are here to talk about legislation that deals with this part (referring to drug, hospital and doctors costs) of the overall health care bill of senior citizens. We also have to recognize that we have a major issue in front of us that has not yet been put on the table but needs to be and that's the question of how are we going to finance these costs, especially with people living longer. While we have something on the order of 25,000 people today who are over the age of 100, it has been estimated that by 2,000, we're going to have something on the order of 100,000 people who are over the age 100. If we think about the aging of our population, about the fact that we're living longer, and about the category of people above 100 years of age, you can imagine how many we're going to have in their 90's, how many in their 80's, how many in their 70's and the tremendous growth in the number of people in those age categories who are going to be facing these kinds of bills. So that's why it's essential that we get this problem into focus and understand exactly what we're dealing with here. Last year, on long term health care, we spent $37 billion. So this is an enormous drain on the assets of seniors. There are heartbreaking cases of husbands and wives running out of money, trying to decide how one or the other is going to be cared for or both are going to be care for, and this is going on in tens of thousands, hundreds of thousands literally millions of cases across the country at the present time. So that's what we're here to discuss today.

Let me introduce our first panel to you. These are people who have encountered first hand catastrophic health problems. They have been very gracious to agree today to come and give us an illustration of what actually can happen when one of these kinds of problems takes place in your family. These things are not easy to talk about and it takes a lot of courage to come and be willing to talk about it and so I am very grateful for them.

The first person is Shirley Roost. She's going to be testifying on behalf of her mother Virginia Hesse Moray, who has rheumatoid arthritis. Mrs. Moray is 79 and has nearly exhausted her resources in order to obtain health care. Mrs. Moray is here also so we'll have the occasion to be able to hear from both of them.

Next will be Helen Borton who is caring for her husband who has Alzheimer's disease. She has exhausted her resources to pay for her husband's care and she'll describe that to us.

And finally, Hollis Turnham who works for Citizens for Better Care as the State's long term ombudsman and who therefore is intimately familiar with what's going in literally hundreds and hundreds of cases in our state.

So Shirley, let us start with you. I'm very pleased to have you and your mother and let me ask, if you will, to get the microphones close enough so that you can be heard and then to speak right into them.

STATEMENT OF SHIRLEY ROOST, INGHAM COUNTY SENIOR CITIZENS OFFICE, TESTIFYING ON BEHALF OF HER MOTHER, MRS. MORAY

Mrs. ROOST. Good morning. There are so many microphones I'm not sure which one you want me to speak into.

Senator RIEGLE. You'll be picked up in both of them there. Maybe they can be sort of aimed together.

Mrs. ROOST. I'm here to speak for mother, because mother is a typical senior whose body has failed her while her mind is still excellent. But mother also had a stroke a couple of years ago and has a partially paralyzed vocal cord and it's hard for her to speak a great deal of time.

Mother's had rheumatoid arthritis for many years. She and my dad both worked, saved, lived through the depression, were frugal people, and as her disease progressed, it got harder and harder for her to do things and more and most costly. They have never had any outside help other than the hospitalization that came with Dad's job which they totally paid for once the plant he worked for shut its doors and they cut his pension. It also cut paying for the Blue Cross so they had to pay for that themselves.

When my father died, that in turn cut mother's income even further. The cost of household help has been horrendous. We paid all that ourselves. They sold their cottage and bought a mobile home in Arizona to help mother because the climate was better. And then when Dad became ill, they could no longer maintain that, so they sold that so that we could help pay for help to keep them both going until Dad died. Then after Dad died I could not continue to run from Mason to Lansing to take care of her all the time and the constant drain of trying to find adequate help to keep her in her home. It's must very difficult to hire people and pay the minimum wage and have them stay very long. You know, it's hard to check their references and everything. In the meantime, we're also buying equipment—orthopedic shoes at $160 a crack, all the medication that we had, her insurance covered some of it, but still even with help with medication her average medical drug bill runs $60–$70 a month. Without that insurance it would be just horrendous. And then wheelchairs and walkers, we've been through so many walkers it's pathetic. As she progressed, it got harder and harder for her to get around. We kept going to more sophisticated walkers. The one she has now is called a platform walker and they're very expensive. As we've gotten into this arthritis thing monther has always supported the arthritis foundation so that we would know what to do. We've found some tools to help her but those are costly, too. And there's no way that Medicare or even Medigap insurance covers any of these things to help her. We are now to the place where mother cannot walk at all anymore. And, we couldn't find any more household help. And, I couldn't work full time and take care of her. I wasn't going to do this [weeping]. So anyway she's in a nursing home now. And when I pay the payment next month Mother won't have any more money left. Everything she and Dad had worked for is gone. And I won't have any more money for her.

Senator RIEGLE. You just take a minute. I know these things are very hard to talk about. It's so important that you come and say this.

Mrs. ROOST. The tragedy is that with some help over the years to help with the household help, mother could still be contributing to society. She'd still be paying rent on her apartment. She'd be actually providing employment for someone. She'd be buying groceries. Mother was on a calling committee and we have a special phone

that we bought for her and everything because she can just use one finger. But mother was still doing things. She could still contribute to the community. But this way, when we go to Medicaid, everybody else is going to have help pay that bill and that's a big bill because it's $2,400 a month I write that check for. Mother's glad to answer any questions if you have anything you'd like to ask.

Senator RIEGLE. First let me say how much we appreciate your coming and testifying. This is emotional. I mean, it makes us all want to cry just to hear a story like this and to know how many hundreds and thousands of stories there are like this even in our own State. So its very important that you come and say this and that we have this as part of public record and so that we understand what's going on and what needs to be done. We understand your feeling and we share that feeling. I'm wondering, Mrs. Moray, would you like to make a comment?

Mrs. MORAY. Well I would just like to say that everyone has been wonderful to me wherever I've been and I appreciate all their help. But it's been very difficult to find adequate and competent help to help with the house work and so forth. And we're not allowed to take that on our income tax. I've still had to pay—I spent all of my savings practically for help to help me at home. I've tried to maintain my own apartment, and plan my own meals and I've tried to get my own help but it's been very difficult. I've had to have surgery on my knees, on my hips, most of my joints have been replaced. And I just don't have the strength in my hands and arms to help myself much anymore, much as I would like to. But I still like to do the same things I did when I was younger. I think that's the way with most senior citizens.

Senator RIEGLE. Let me ask you both this. It seems to me that if we were to develop a national health care insurance system where everybody was part of it—with the whole population of the country in the base of the people who were paying something in and then getting the protection—in that situation, the people who then get hit with serious health problems such as you have experienced could draw on the funds of that insurance pool. Their basic health needs could be met without having to exhaust all of their savings so that they could still live decently. Not everybody would need that help. Only some would; that's the whole idea of an insurance plan. If we insure everybody at once, we know some people are going to need the benefits—they are the ones that have the tough luck to need the benefits. The others who are lucky enough not to need the benefits pay in a small amount. They may never need to get the benefits, but they know that if they should be stricken, then they'll have the protection, too. And that's the whole idea of a broad insurance plan. It seems to me we have to think about, as a society, whether we want to take the step to develop a broad based insurance system—Medicare was the start—that goes beyond Medicare to deal with situations like this. Here you've got hard working people who have saved all their lives but then get hit with a succession of medical bills that can go on for 10 or 20 or 30 years—beyond anybody's capacity to pay for them. If we don't have an insurance system then we're going to have literally more and more of these impossible situations arise. After you've had a chance to hear from some others, I'm going to ask for a show of hands as to how

you feel in the audience about whether you think we are at a point as a nation where we need to take that step, to face up to this problem and construct a system of that kind. We would need to be willing to pay for it but we would know what we're getting with the money. So I put that question out there now for you to think about and in a little while I'm going to ask you for a show of hands on that question.

But again, I want to thank you both.

[The prepared statement of Mrs. Roost follows:]

TESTIMONY OF SHIRLEY ROOST, INGHAM COUNTY SENIOR CITIZENS OFFICE, TESTIFYING ON BEHALF OF HER MOTHER, VIRGINIA HESSE MORAY

My name is Shirley Roost, and I am here to testify on behalf of my mother, Virginia Hesse Moray. Mrs. Moray, age 79, is a resident of the Ingham County Medical Care facility on Dobie Road in Okemos. She has had rheumatoid arthritis for approximately 40 years. Over the years, her medical expenses have steadily crept up. Most of these expenses were for a long time covered by her job, her husband's job, and their joint insurance. Since retirement, however, Mrs. Moray's medical expenses, and the failure of Medicare to cover those expenses, have wiped out practically everything she and her family had built up. Mrs. Moray retired on Social Security disability at age 60. The Morays sold their summer home and bought a trailer in Arizona in the hope that the warm dry climate would help her. They spent twelve winters there. When Mr. Moray became ill, the mobile home was sold and the money used to hire outside help to care for both of them. This was necessary because Mrs. Moray's arthritis is so severe that she cannot do even the simplest things for herself, such as dressing. When Mr. Moray died in 1980, his pension (already cut in half when the Diamond Reo plant closed) was cut in half again leaving Mrs. Moray with barely enough to cover her Blue Cross payment. This Blue Cross plan was under a UAW group plan for retirees, but had to be paid by each individual since the plant closed. With her expenses, Mrs. Moray did not feel that she could drop that coverage or change to anything less costly. Without the joint income, Mrs. Moray has had to use her savings to meet expenses. She has spent between $30 and $40 thousand dollars to meet medical expenses not covered by Blue Cross or Medicare. Her copayment on prescription drugs alone averages $50/month. Because of her disability, Mrs. Moray must have 24 hour help to take care of herself since her mother died. This kind of help is very hard to come by. In order to take care of her, I sold the family home and moved her into an apartment near me. We have used all of the money from the sale of the house to pay for more medical expenses. These include orthopedic shoes at $120/pair, glasses, and home help, none of which is covered. In addition, Mrs. Moray has had three hip replacement operations, four knee replacements, orthoscopy on both shoulders, all of her toes straightened, two cataract operations, and now because of the medication, mouth surgery and complete bridge work. Help has been the worst ongoing problem, and would have been much worse had I not worked with the aging and been familiar with the services available. My mother has had no outside financial help. She has exhausted all of the assets that she and her husband have worked all their lives for. And I think it's shameful that her only hope of survival is to pay out her last few dollars so that she can qualify for Medicaid.

Senator RIEGLE. Now I want to go to our next witness and that is Helen Borton. Helen, let us get the microphones over in front of you. We thank you for testifying. When you're ready why don't you just begin.

STATEMENT OF HELEN BORTON

Mrs. BORTON. Good morning. I guess the most devastating thing I've ever known is Alzheimers disease and my husband was diagnosed with having this in 1980. I cared for him at home—I was the basic care giver—for as long as I could. And I guess leading with my heart I thought I could keep him at home and never have to put him in a nursing home. But last fall I had to do this. My chil-

dren have all been very supportive and they've all helped all the times they could. But it's just a devastating thing to see a husband change so much. He was always a leader, always on top of everything. He was in business. From the time this was diagnosed—it came on very gradually—and so I had never heard of it really—I just couldn't imagine that this change was coming about. Toward the end that he was home he was like a frightened child. He called my name over and over all day long. He was afraid, I guess, that I wouldn't be there for him. So finally I had to take the step of admitting him.

I was advised that I could take legal steps to transfer property—I had two options—or I could get a divorce. After 33 years of marriage and I felt like someone had punched me. I mean to tell me this. I was literally torn apart when I left the attorney's office but he felt he had to tell me this, so that I would have money for my future. Well I don't need money that bad. It will come from somewhere. The Lord will provide, I know. I just wish that—I know there are a lot of things to be researched—we hear so much about other things—but I wish more money appropriated for Alzheimers disease research. Because today he is very near to be being bed ridden. The last time he was home my son carried him into the house when he came home to visit and he's growing weaker all the time. I guess that's about all I have.

Senator RIEGLE. Well Helen I want to thank you, too, for coming and testifying, and telling us this story. I know it's not easy to talk about these things. So now you're spending about 21 hundred dollars a month for his care in nursing home.

Mrs. BORTON. Yes.

Senator RIEGLE. Your savings is disappearing, of course, as you're doing that. You were told by your lawyer that one way you could protect the assets is if you were to get a divorce which you are not going to do and which is a horrible thing even to have to think about or be told. Your husband has one of these health care illnesses that goes on as long as he is alive. When we think of catastrophic illness, sometimes we think of a heart attack or we think of some other serious fall or accident that requires cares in the hospital and so forth. But we should also be thinking about Alzheimers disease or some other chronic illness of this kind that goes on for years as a castastrophic health problem because clearly it is. It's been a catastrophe in your family.

Mrs. BORTON. Yes.

Senator RIEGLE. It's been a financial castastrophe for you and an emotional catastrophe.

Mrs. BORTON. Yes, that's right.

Senator RIEGLE. I think you made the point about the need for more money for research for Alzheimers and there are a lot of things like this. We've got the AIDS problem right now which needs research money.

I want to just mention one big expensive item that is before the Federal Government right now because it relates to this and the question of what are we going to spend our money on and do we have enough money for the things we need and so forth. There's a proposal to build what is call the Star Wars program. The Star Wars program costs $1 trillion. Now a trillion dollars is a thousand

billion. A thousand billion dollars is a trillion. Most of the people I talk to who understand the technology think it's a hair brained scheme. But that's one of the decisions that we are facing as a nation. One of the things we ought to think about is whether we should take part of that money as one possibility—just a part. As I was saying earlier we are spending $37 billion a year on long-term health care. Well, $37 billion is a very, very small part of one trillion. I think we are going to have to make some very careful decisions as a nation as to which road it is we want to go down. If we want to go down the road of meeting the human needs of our people in this country, then we are going to have to face up to problems like what we just heard from these two witnesses, and what we will hear from others in this audience that have come in today and who will stand up later and tell their stories.

I think this may be a good time to put the question to the audience as a whole. You will hear more as the morning goes on, but how many of you here feel that we have come to a time in our country where we need some kind of broad-based insurance plan that covers the whole country, that can meet these catastrophic health care bills for families such as we have seen here? I'd like those that feel that it is time for the country to take this step to raise their hands so we can see what kind of support there is for that kind of step. [Audience complies.] Let me just invite the cameramen here to shoot out there and see all these hands up in the air because these folks ought to have a chance to express their opinions—whether you take a picture or not, it ought to be seen. And how many now are not convinced of that or how many think that we really shouldn't go down that road or you have serious reservations about it? I would like you to raise your hands. [Audience complies.] Let's see the hands. There are a few one, two, three, four, five. I see five hands up. So there are people who have reservations about it and that's not surprising in a democracy. But what I think is very powerful in that show of hands is the overwhelming support in this audience to move ahead and do something substantial about this problem. So it's important that we have that on the record. Let me now go to our next witness who is Hollis Turnham. Hollis, let us now hear from you in terms of the situations that you've been seeing in the testimony that you have to give us today.

STATEMENT OF HOLLIS TURNHAM, EMPLOYEE OF CITIZENS FOR BETTER CARE

Ms. TURNHAM. Thank you, Senator. As you mentioned earlier I am the State's long term care ombudsman and I work for Citizens for Better Care, a membership organization looking to maintain and improve the quality of care in the State's long term care facilities. The testimony that you heard earlier demonstrates graphically the issues that we face as a society and I think you stated them succinctly earlier. It is, are we going to take on long term care? Are we going to recognize that we as a society have generally done an OK job dealing with acute illness, but when it comes to chronic disease—diabetes, arthritis, Parkinsons, osteoporosis, high blood pressure, stroke, Alzheimers—are we going to recognize them the same way we recognize acute illness? We believe that it's time that

we do. That doesn't mean that the Medicare system now is bad or evil or wrong. It simply represented our thoughts in 1960. We are now in 1980 and we need to design a health care system for now and beyond that recognizes that chronic illness is the problem we need to face.

Another issue that we need to come to grips with, and that we have done some work on so far, is the major effects that the new reimbursement system that hospitals have, called prospective payments or DRG's, has had on the health care system. Congress rightly decided that something needed to be done about the escalating cost of hospital health care. The issue now comes to how is Congress going to deal with the after-effects of policy decisions to discharge people quicker and sicker so that they are doing their convalescence either at home or at nursing homes? And, Congress, and I think more particularly, the Health Care Financing Administration, has got to stand up to that issue. We've identified some of those issues, related to the DRG system and have moved forward with that.

I think the unanimous reaction of senior advocates has been that the Reagan-Bowen proposal, while it is a first step, is not enough mainly because it doesn't look at long term care. I would also say, to give you the point in example, Senator and also a major concern that we have—even if the Medicare system is improved in terms of benefits and coverage, our experiences as advocates and beneficiaries is that the Health Care Financing Administration really doesn't care what Congress tells it. It does what it wants to do and on a daily basis denies valid claims particularly for nursing home care and for home health care. HCFA's failure and refusal to acknowledge valid nursing home and home health claims is a national scandal and is comparable to what the Social Security Administration was doing a couple of years ago to disability claims.

Simply increasing home health care benefits or skilled nursing benefits is not going to work because unless somebody gets control over HCFA, so valid claims are paid, it's going to be a hollow motion by the Congress. We as advocates face a monumental task convincing nursing homes and home health agencies to do the good fight, to file those claims, and to pursue the appeals and we have done our part. We have done community education; we have done articles. We have encouraged families to go through that. And when families do go through it, they do win. The problem that's faced, Senator, is when people file a claim or attempt to file a claim, it's denied. Their given rights of 100 days of skilled nursing home care in a nursing home is cut off wrongfully. And many people, because they don't want to get into the situation of divorcing a husband or using their entire assets and leaving a spouse totally impoverished, will take people out of nursing homes into situations in which we, as advocates, many times feel they are not capable of giving the care that that person needs. Too many stroke patients are not getting the physical therapy that they need because HCFA has said that a stroke patient only gets 10 days of Medicare coverage. That has got to be changed.

It is quite heartening to us to see that certain Members of the House are suing the Health Care Financing Administration over the home health benefits issues—that beneficiaries, home health

agencies, Congressmen Pepper and others are suing Secretary Bowen, saying "we are not going to allow this to continue. You better pay those claims." It is important that that happen. It is important that prescription drug coverage be affordable to seniors in order to control their chronic conditions of arthritis, and high blood pressure, and we support those activities. And all I can say is to again repeat, Senator, I agree with you. We have got to decide as a society if we are going to care for the chronically as well as the acutely ill.

Senator RIEGLE. Hollis, thank you very much. That's a very powerful statement and it's a very helpful statement for us to have.

[The prepared statement of Ms. Turnham follows:]

PREPARED STATEMENT OF HOLLIS TURNHAM

My name is Hollis Turnham and I work for Citizens for Better Care (CBC) as the State's Long Term Care Ombudsman. Citizens for Better Care is an 18-year-old membership non-profit organization dedicated to improving the quality of care and life in Michigan's nursing homes, homes for the aged, and adult foster care homes. As such, it has been the host agency for the federally mandated State Long Term Care Ombudsman project since 1972 through funding from the Michigan Office on Services to the Aging.

CBC's Board, members and staff thank you for the opportunity to talk about some of the health care needs of Michigan's Medicare beneficiaries. In keeping with our agency's primary mission, we would like to focus on Medicare and long term care in the on-going discussions about the so-called "catastrophic health care coverage."

Let me first take a few moments for definitions. When we at CBC talk about the long term care system or continuum, we are envisioning a full range of services and facilities from a skilled nursing home to the "simplest" in-home public health service.

It is very important that all of us face an historical reality . . . the current Medicare system was not designed to deal with the chronically ill and therefore does a very poor job in providing long term care. The current system was designed to deal with health care as we knew it in the early 1960's. Our health care system and our populations have radically changed since that time.

Those changes do not mean that the current Medicare system is "bad" or "evil" merely in need of what some would call "radical changes" to meet the health care needs of its beneficiaries in the 1980's and beyond.

For some, that radical change will and needs to be a recognition of chronic illness and treatments and costs. While Medicare beneficiaries are generally well protected from the financial ravages of "acute illnesses," the financial costs associated with chronic illness and the long term care continuum are not recognized by Medicare. The unanimous reaction of Medicare beneficiaries to the "Bowen/Reagan proposal" that "it ain't enough" is a direct result of the current system and the Bowen proposal's inadequacies.

CBC firmly believes that the treatment and therefore the costs of chronic illness must be recognized by the Medicare system. Specifically, the coverages afforded Medicare beneficiaries using nursing homes and home health agencies MUST be improved.

Great improvement in those benefits can and should occur without changing the benefit period currently provided by the law. Great improvement can and must occur by clearly instructing, mandating, and guaranteeing that the Health Care Financing Administration (HCFA) approve valid claims for the skilled nursing home and home health care.

HCFA's failure and refusal to grant to beneficiaries their current skilled nursing home and home health benefits is a national scandal equally pervasive and illegal as the Social Security Administration's recent denials and terminations of disability benefits. Many skilled nursing homes and certified home health agencies have simply given up on the Medicare system because of the consistent denials of the claims submitted by them on behalf of their patients. Advocates face a monumental uphill battle in convincing beneficiaries and providers to file the claim, the request for reconsideration, the hearing request, and find the legal assistance necessary to ultimately win claims.

I have attached a copy of the Medicare appeal rights brochure CBC has developed in order to facilitate the fight for Medicare nursing home benefits.

And the critical fact is that BENEFICIARIES DO WIN CLAIMS IF APPEALED . . . 82% of the requests for reconsiderations and hearings are won by the beneficiaries. But the winning comes months of years after the service was delivered and many times the patient has died during the fight for Medicare benefits.

The most graphic proof of HCFA's failure to follow current Congressional mandate can be found in the work of Legal Assistance to Medicare Patients (LAMP) in Connecticut. LAMP is the legal assistance project that wins 82% of its Medicare benefits cases; has consistently filed and won judicial decisions denouncing HCFA's practices (Fox V. Bowen, regarding physical therapy patients in skilled nurisng homes) and serves as a model for all the other states setting up LAMP projects.

It is heartening to see that Medicare beneficiaries seeking home health benefits, certified home health agencies, and members of Congress are suing Secretary Bowen and HCFA to stop the illegal denials of their benefits. (See Duggan v. Bowen)

While CBC agrees that Medicare coverages should be extended to cover the costs of health care associated with chronic illness and the long term care continuum such as prescription drugs, great financial relief from the catastrophic costs of illness can be provided by forcing HCFA to honor and enforce the current law.

Thank you for this opportunity.

Senator RIEGLE. I got a note a minute ago that indicated that some of the press people who were here were going to have to leave around 11 o'clock and wanted to ask two or three questions before they left. Is that still the case? I want to be sure that we answer any questions that they have before they go. I think what we will do here before we go to our next panel is take about a 5 minute recess—long enough to answer their questions—and then we will reconvene. I don't want to lose the momentum we have here because I think we heard very powerful testimony here this morning and we are going to hear other testimony from this next panel and from others in the audience who have come here from across the State to tell their stories. We will take a 5 minute recess so that people can stretch their legs. I would like to get back in place in very short order so that we can continue to move forward.

[Recess taken.]

Senator RIEGLE. Let me ask, if you will, to find a seat. We had, just before we broke, about 250 people here in the audience, which is a tremendous turnout for a hearing of this kind when you figure this is a weekday morning. I want to thank all of you for coming.

Our next witness is Libby Maynard. Libby serves as the director of the Michigan Office of Services to the Aging. She is accompanied by Mr. Robert McReavy. She will be speaking on behalf of the Medicare task force which has been looking at how to improve the Medicare program from a Michigan perspective. We are delighted that she is here with us today and I know some of the comments that our earlier panel gave will fit into some of the things that you will say. So we would like to hear from you at this time.

STATEMENT OF OLIVIA P. MAYNARD, DIRECTOR, STATE OF MICHIGAN, OFFICE OF SERVICES TO THE AGING

Ms. MAYNARD. Thank you so much Senator Riegle, and certainly we are most fortunate in this State to be served by a person who is committed to the cause of preserving the dignity and independence of older Michiganians.

Health care is a central concern to our State's aging population and our offices needs assessments of the 60 and over population finds that access to affordable, quality health care is on the top of

the list, right next to the difficulty that seniors have in maintaining adequate income. And health care was the only issue at the senior power day this year.

Given the critical role of Medicare to the lives of our State's aging population and the varying proposals that have arisen to reform the program, including the Bowen proposal, I appointed a task force to prepare a report of Medicare reform and so I speak today for all the members of that task force. It is made up of representatives from the provider community, State government, academia, health care purchasers, health insurers, and the senior advocacy network. I have handed in with my written testimony the list of those members.

Senator RIEGLE. We will make that a part of the record.

Ms. MAYNARD. Very good, thank you. The task force has met now since early May and has reached a general agreement over what we believe Medicare should be and what principles Congress should follow in crafting a new Medicare program. While the final report will be given later to the Congress and to the State of Michigan, I will share with you our statement of purpose and principles. First, OSA Medicare task force has adopted the following statement of purpose for Medicare: that Medicare should be a Federal program to provide insurance for the elderly and other categorically eligible persons that guarantees access to social, health, and long term care services. Specific benefits, methods of finances and under writing programs policy in administration should promote this purpose.

With regards to the benefits that Medicare should provide and the mechanism for financing these benefits, the task force, after long and careful deliberation, arrived at the following recommended principles for the Congress to consider. First, in addition to acute medical care, Medicare coverage should be expanded to include custodial long term care in home and community settings, skilled home health care, custodial long term care in an institution, prescription drugs, mental health services and prescriptive therapies. Second, Medicare should be established as a primary reimbursement source for institutional care. In addition, current administrative barriers to payment of skilled nursing services and home health benefits should be removed. And, further reimbursement exclusions for acute medical services delivered outside the hospital setting should be eliminated. In this way, equity in payment and benefits regardless of setting could be assured.

Any discussion of expanded benefits without an acknowledgement of the cost and a way to pay for them is incomplete and therefore the task force did prepare a list of recommended principles for financing this system. They are really inseparable from the ones dealing with benefit coverage. But I want to preface the list with the observation that many of the task force, and certainly we saw it reflected here, are deeply troubled with the emerging trend in Medicare beneficiary financing which imposes a greater cost sharing burden on the poor and the sick. Medicare beneficiaries are paying, on the average, 16% of their personal income for out-of-pocket medical expenses today and are projected to pay an average of 19% by 1990. According to Harvard University's estimates, the poor and the sick pay through the use of deductibles and copay-

ments on the average of 25% of their income for out-of-pocket medical expenses. And what is doubly distressing about these figures is that they do not include the cost resulting from long term care in an institution. The current system of financing long term care puts Medicare almost completely outside and leaves to individuals and Medicaid the shared responsibility of paying for nursing home care. As you well know, Medicaid will pay the nursing home bill only after one has become a pauper and qualifies for welfare. And stripping people of their economic independence and personal dignity at the end of their lives is the true catastrophic illness which President Reagan and Secretary Bowen have not looked at with their promised deliverance of the last full measure of security for our aging population. We hope that Congress will correct this glaring omission. In financing Medicare, the task force recommends; first, Medicare copayments and major deductibles should be eliminated and replaced with a single universal premium that provides funding for part of the program. Two, the Medicare premium should be structured so as to afford protection to low income beneficiaries. Inability to pay the premium should not be the basis for non-participation in Medicare. Premiums for those unable to pay shall be paid by the government. Three, Medicare reimbursements should be sufficient to assure access to care and discourage provider cost transfers to other patients. Four, benefits and reimbursement policy designs should promote the most efficient use and delivery of services and be sensitive to human need and cost containment of objectives. And, five, employer savings that result from the change in Medicare benefits should be passed on to retirees who would otherwise pay more out-of-pocket for health care than they are currently paying. Changing the scope of Medicare coverage while at the same time paying for it through an insurance premium mechanism is only one art of the needed reforms in Medicare. Making sense of Medicare today seems to require a PhD in government forms. The program has become so complex and confusing that our office, in conjunction with the Area Agency Association, American Association of Retired Persons, Blue Cross/Blue Shield of Michigan has initiated a Michigan Medicare Advocacy Program. Its purpose is to help Medicare beneficiaries throughout Michigan with the problems of filing and claiming an initiating appeals. But even with that, charting the course on this system is a herculean effort.

The task force has prepared a list of recommendations for simplifying Medicare. First, the Parts A and B, be combined into a single program, that patients should not be required to pay providers first and than submit their bills to Medicare. Instead, providers should be required to bill Medicare in all cases, preventing providers for billing patients in advance of Medicare reimbursements. And an independent ombudsman service should be established within the Medicare system to assist beneficiaries with accessing services, to serve as an advocate for and protect the rights of patients, and to assist patients with the explanation of Medicare benefits inquiry and appeals process.

We have entered an era of chance in the delivery of health care system. DRG's, IPA, HMO, PPO, SHMO are all abbreviations that are a secret language except for those that are initiated into health care delivery systems. They also foreshadow the future of health

care delivery. For this reason the task force has prepared recommendations relative to this emerging trend. First, that any effort to move Medicare into a capitated health care delivery system must be balanced with a vigorous quality assurance program and adequate patients safeguards. And secondly, that to the extent that consumer groups are able to negotiate prepaid contracts with providers for delivering affordable, quality health care at no additional cost to the government. Medicare regulations and law such as the requirement to pay deductibles and copayments should not impede this cooperative effort. It is our task force hope that our efforts here in Michigan to build a consensus around reform of Medicare are being duplicated in other States. We believe that what you do in Washington with Medicare will have long range consequences across the country and into the 21st century. Therefore, on behalf of the members of the task force and the older population in Michigan, I want to commend you again Senator Riegle for renewing your long-standing interest in, and commitment to, the lives of Michigan's older adults. Thank you.

Senator RIEGLE. Thank you very much. That's a very important set of recommendations you have given us and I appreciate the work of your group. It's not easy to plow through all of these questions and issues and come up with a set of comprehensive recommendations such as you have done. But that's a fine piece of work and we are very grateful to have it.

Ms. MAYNARD. Thank you.

[The prepared statement of Ms. Maynard follows:]

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OFFICE OF SERVICES TO THE AGING

OLIVIA P. MAYNARD, Director

U.S. Senate Hearing

June 29, 1987

Lansing, Michigan

Testimony by

Olivia P. Maynard, Director
Office of Services to
the Aging

Good morning Senator Riegle. I am Libby Maynard, Director of the Michigan Office of Services to the Aging. Welcome back to Lansing. I am sure that everyone here will agree with me when I say that we are indeed fortunate in this state to be served by a Senator such as yourself who is committed to the cause of preserving the dignity and independence of older Michiganians.

As a member of the Senate Finance Subcommittee on Health, which passes judgment on legislation affecting Medicare, you are to be commended for coming home to listen to your constituents who depend upon Medicare for preserving their health. I am not surprised by the turn out not only here in your Lansing public hearing, but also at your other hearings in Warren and Flint.

Health care is a central concern to our state's aging population. OSA's needs assessment of the 60 and over population places access to affordable, quality health care at the top of the list right next to the difficulty seniors have in maintaining adequate income. Health care was the only issue raised in this year's Senior Power Day Platform.

Given the critical role of the Medicare in the lives of our state's aging population and the varying proposals that have arisen to reform the program, including the Bowen proposal for catastrophic costs associated with acute care, I appointed a task force to prepare a report on Medicare reform. The task force is comprised of representatives from the provider community, state government, academia, health care purchasers, health insurers and the senior advocacy network. I have appended a list of the members and their designates. As you will see from this list, we have attempted to include a broad cross section of economic and social interests in the process.

The Task Force was divided into three subcommittees, each chaired by a Commissioner from the Michigan Commission on Services to the Aging. I am joined at the table by the three subcommittee chairs, Al Rightley, who also chairs the Commission, Robert McReavy, and Richard Rienstra. Mr. McReavy's subcommittee reviewed the Medicare Benefits component of reform while Mr. Rienstra's subcommittee pursued recommendations relating to Administrative Simplication and Future Health Care Delivery Systems. Mr. Rightley chaired an advocacy subcommittee which has assisted us in advancing the significant work of the Task Force.

The Task Force has met since early May and has reached a general agreement over what we believe Medicare should be and what principles Congress should follow in crafting a new Medicare program. While we intend to issue a final report to the Congress and the people of Michigan by the end of July, your presence here in Lansing affords us the opportunity to share with you our statement of purpose and principles. Firstly, OSA's Medicare Reform Task Force has adopted the following statement of purpose:

> **Medicare should be a federal program to provide insurance for the elderly and other categorically eligible persons that guarantees access to social, health, and long term care services. Specific benefits, methods of financing and underwriting, program policies and administration should promote this purpose.**

With regard to the benefits that Medicare should provide and the mechanism for financing these benefits, the Task Force after long and careful deliberation

arrived at the following recommended principles for Congress to consider:

1. **In addition to acute medical care, Medicare coverage should be expanded to include custodial long term care in the home/community setting, skilled home health care; custodial long term care in the institution, prescription drugs, mental health services, and prescriptive therapies.**

2. **Medicare should be established as a primary reimbursement source for institutional care. In addition, current administrative barriers to payment of skilled nursing services and home health benefits should be removed and further, reimbursement exclusions for acute medical care services delivered outside the hospital setting should be eliminated. In this way, equity in payment and benefit regardless of setting could be assured.**

Any discussion of expanded benefits without an acknowledgement of cost and a way to pay for them is incomplete. Therefore, the Task Force prepared a list of recommended principles for financing the Medicare system. These principles are really inseparable from the ones dealing with benefit coverages.

I should preface this list with the observation that the Task Force appears to be deeply troubled with the emerging trend in Medicare beneficiary financing which imposes a greater cost sharing burden on the poor and the sick. Medicare beneficiaries are paying, on the average, 16% of their personal income for "out of pocket" medical expenses today and are projected to pay on the average 19% by 1990. And yet according to Harvard University's estimates, the poor and the sick pay through the use of deductibles and co-payments on the average 25% of

income for "out of pocket" medical expenses.

What is doubly distressing about these figures is that they do not include the costs resulting from long term care in an institution. The current system of financing long term care puts Medicare almost completely outside and leaves to individuals and Medicaid the shared responsibility of paying for nursing home care. As you well know, Senator Riegle, Medicaid will pay the nursing home bill only after you have literally become a pauper and qualify for welfare. Stripping people of their economic independence and personal dignity at the end of their lives is the true catastrophe that President Reagan and Secretary Bowen have quite carefully chosen to overlook in their promised deliverance of the "last full measure of security" for our aging population. We would hope that Congress will correct this glaring omission.

In financing Medicare, the Task Force recommends that:

1. Medicare co-payments and major deductibles should be eliminated and replaced with a single, universal premium that provides funding for part of the program.

2. The Medicare premium should be structured so as to afford protection to low income beneficiaries. Inability to pay the premium should not be the basis for non-participation in Medicare. Premiums for those unable to pay shall be paid by government.

3. Medicare reimbursements should be sufficient to assure access to care and discourage provider cost transfers to other patients.

4. Benefit and reimbursement policy design should promote the most efficient use and delivery of services and be sensitive to human need and cost containment objectives.

5. Employer savings that result from a change in Medicare benefits should be passed onto retirees who would otherwise pay more out of pocket for health care than they are currently paying.

Changing the scope of Medicare coverage while at the same time paying for it through an insurance premium mechanism is only one part of the needed reforms in Medicare. As I am sure your staff will tell you, making sense of Medicare today seems to require a Ph.D. in Government Forms. The program has become so complex and confusing that OSA in conjunction with the Area Agencies on Aging Association of Michigan, the American Association of Retired Persons, and Blue Cross/Blue Shield of Michigan has initiated a Michigan Medicare Advocacy Program. Its purpose is to help Medicare beneficiaries throughout Michigan with the problems of filing claims and initiating appeals. Even with MAP, throwing light on this system is a Herculean effort. Consequently, the Task Force has prepared a list of recommendations for simplifying Medicare. They are:

1. Parts A and B should be combined into one single program.

2. Patients should not be required to pay providers first and then submit their bills to Medicare. Instead, providers should be required to bill Medicare in all cases thereby preventing providers from billing patients in advance of Medicare reimbursements.

3. An independent ombudsman service should be established within the Medicare system to assist beneficiaries with accessing services; to serve as an advocate for and protect the rights of patients; and to assist patients with the Explanation of Medicare Benefits inquiry and appeals process.

Finally, we have entered an era of change in the delivery of health care motivated in part by a desire to contain costs and to operate efficiently. DRG, IPA, HMO, PPO and SHMO are not the letters on a eye doctor's chart. They are meaningful abbreviations which act like a secret language that is comprehensible to only the true initiate. However, they also foreshadow the future of health care delivery. For this reason, the Task Force has prepared recommendations relative to this emerging trend in health care delivery toward captitated systems. They are:

1. Any effort to move Medicare into a capitated health care delivery system must be balanced with vigorous quality assurance programs and adequate patient safeguards.

2. To the extent that consumer groups are able to negotiate prepaid contracts with providers for deliverying affordable, quality health care at no additional cost to the government, Medicare regulations and laws, such as the requirement to pay deductiables and co-payments, should not impede this cooperative effort.

We would hope that our efforts here in Michigan to build a consensus around a reform of Medicare are being duplicated in other states inasmuch as we believe that what you do in Washington with Medicare will have long range consequences across the country, but across the threshold that separates the twenty first century from the twentieth. On behalf of the members of the Task Force and the older population in Michigan, I want to commend you again, Senator Riegle, for renewing your longstanding interest in and commitment to the lives of Michigan's older adults. We are confident that with your leadership, Congress will make a significant advance in protecting the dignity and independence of all of us as we age.

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Senator RIEGLE. Mr. McReavy did you want to speak at this time?

Mr. MCREAVY. Well I didn't intend to speak but, through the last year or so the commission has been sitting in the same position that you are now and if you could hear the grass roots all over the State of Michigan talk about things that we hear it would really inform you a great deal. I am not going to say any more I think we have said enough.

Senator RIEGLE. Can I ask you where you have had your field hearings?

Mr. MCREAVY. Well, we have been in Marquette, we been in Muskegan, Kalamazoo, Alpena, and the last one was in Mount Pleasant. Also we had two in Detroit. I might say that the home delivered meals are a very important thing. That's for people we are talking about right now. Many of those people came in wheel chairs and walkers with people helping them and you know they needed help or they wouldn't have gone to all that trouble to come. And they said thank goodness for the meal program but we are hungry on the weekends. You know we only usually operate 5 days a week.

Senator RIEGLE. Yes we haven't figured out how to just eat just 5 days a week. There are 2 more days of the week we need to eat.

Mr. MCREAVY. I think they get pretty hungry by Monday. And also especially at the Mount Pleasant hearing—you know the Michigan legislature is considering House Bill 1414 which is help for people with prescription drugs. And I would say that probably at least half of the people who got up to speak said we also support HB 1414. So you know what we are talking about here today is what people are talking about out there in the State.

Senator RIEGLE. Well, I thank you for those comments and we are going to have a whole series of witnesses who have come in who want to speak here this morning. So we're going to get more of that kind of testimony. I appreciate very much work of the commission and what you have said.

I think now I am going to go to our last panel and let me just introduce the three panelists. We will call on them and then we will go to the audience. The first is Wendy Dillmann who is a nurse with the Tri-County Office on Aging. As part of a care management team, Ms. Dillmann works to help coordinate services for frail and elderly persons in their homes. She works with community services medical services as well as services within the system such as Medicaid. Then we will hear from Charles Ellstein who is the senior director of the health finance department for the Michigan Hospital Association. In this position, Mr. Ellstein directs all health finance activities for Michigan Hospital Association and is a respected health care professional. Then we will hear from Dr. James O'Brien, who is the director of the section on clinical geriatrics at Michigan State University. He did his premedical and medical studies at the University College in Dublin. Dr. O'Brien was a geriatric fellow with the Center for Aging and Human Development at Duke University and now serves in the Department of Family Practice at Michigan State University. These three witnesses can really bring a prespective from the point of view of health care providers. So Wendy let us hear from you first.

STATEMENT OF WENDY DILLMANN, TRI-COUNTY OFFICE ON AGING, CARE MANAGEMENT, LANSING, MI

Ms. DILLMANN. Good morning. I have worked as a nurse over 10 years. The last 5 of these 10 years I have worked with the elderly over the age of 65. For the last 2 years I have worked in the care management program in the greater Lansing area. I am a nurse and I have been that way for 10 years. That's what I start out with. During this time I have worked with the elderly not only their medical needs but their financial needs. Based on my experience with the elderly I feel the proposed legislation expanding Medicare to include the catastrophic acute care benefit is needed and it is a good first step. It's very encouraging to see all the efforts being made to identify what limitations the new benefit has. There is no doubt that the elderly need help with their medical expenses. It is important to take a closer look at these expenses to see where the help could be most useful.

I would like to address three areas of need I see in working with the elderly. First is the need for education, not only with seniors but with all age groups. It is paramount that we address the aging process and the consequences it is having. I think not only for the person but the family and others around them. We should familiarize everyone with the certainty of increasing health needs and the current means for dealing with these health needs. Plus, project ahead what is needed if new alternatives are not sought.

I would ask to share with you the case of Mr. and Mrs. T. Mr. T. has had Alzheimer's disease for 2 years and is now coming to the stage where she requires more and more care. When we met this couple, he was fairly able to care for Mrs. T. at home. As time wore on and the care needs for his wife increased, he became more fatigued, more irritable and less understanding. His own age, 82, became a factor in his ability to provide care. As he was wearing out, he needed help in the home or somewhere Mrs. T. could go so he could be relieved of this burden. He thought, incorrectly, that he could get a room in a nursing home for Mrs. T, and have Medicare pay for it. (A study by AARP shows that Mr. T. is not alone. 79% of AARP respondents polled believed incorrectly that Medicare will pay for nursing home stays.) He was unaware that due to the chronic nature of Mrs. T's illness, Medicare will give no assistance at all for the home care.

A second case that supports my suggestion of an added need for education is the case of Mr. & Mrs. N. Mr. N. had just retired when he was hit by his first stroke. Thereafter, he had a series of multiple strokes that left him wheelchair bound and unable to care for himself. He has a chronic condition, a long term illness, that is not improving so he no longer goes to the hospital when a stroke occurs. He received skilled nursing for a short time following an episode. The couple had not expected what befell them. They are still young and still paying on a home mortgage and a car mortgage. Mr. N. requires tiring 24-hour care, plus Mrs. N. must perform all of the household tasks for him. Mr. & Mrs. N.'s budget is very tight. There is no money left over to get help in to relieve Mrs. N. even for 1 day a week. So she is there 24 hours a day. If Mrs. N. put her husband into a nursing home, along with the

stress she would feel about him going in, she would lose all of his income, and that's a major portion of their budget. This is real common in the elderly I have seen. The woman's budget is usually lower than her husband's. This becomes a critical factor, if she is supposed to put him into the nursing home. Often she can't do that. Mrs. N., at the early age of 63, would likely lose all of the security that she and her husband have worked for. She would lose her home, she would lose her car. Mrs. N. believed that Medicare would pay for at least home care. She already had the understanding that part of it would not be paid for in the nursing home, but she didn't know why.

The second area I would like to address is the need for greater expension of the catastrophic benefit. I feel a greater majority of elderly would be helped if the expansion could be pointed more toward improvement of benefits for those requiring long-term care. I feel this is necessary to prevent the impoverishment of the chronically ill person as well as the spouse. I am really scared by figures I hear, that 4 out of 5 elderly over 65 have illnesses not covered by Medicare, the chronically ill. 6 out of 7 people would be devastated by the cost of long-term care. I don't want to play down the benefits of the catastrophic benefit. I think they are really needed. The elderly need the skilled nursing home days—the increase in them—the unlimited hospital days, the no prior hospitalization to skilled nursing facilities, and many others that are outlined in the benefit. But from my experience as well as the figures I have seen, the catastrophic benefit would only help a few of the elderly. In most of the clients I have found the usual hospital stay is from 7 to 10 days. The most I have seen is about 30. AARP reports that the usual hospital stay is 7.8 days. So an extension on the hospital days would not greatly affect the majority of the people I work with. The cap on out-of-pocket expenses, as I understand it, does not include doctor charges greater than the Medicare-approved fees. Four out of five doctors I have seen charge more than Medicare approves. Neither does the cap help pay for eyeglasses, prescriptions, long-term care, hearing aids, dental services or custodial care.

In the past 2 years I have seen many clients that need help with medical expenses. Many of these expenses are related to chronic illnesses. The case of Mr. & Mrs. M. reflects what could happen to a couple in their early 60's. Neither of them has Medicare as they are not old enough. Mrs. M. had a stroke a few years ago that left her partially paralyzed and now she needs total 24-hour care. They have gone through their savings, extended their credit to the limit. Mrs. M. had a stroke 2 years ago that left her partially paralyzed and necessitates 24-hour help. Financially they have gone through their savings, they have extended their credit and have become real creative in extending their credit, have sold off all salable assets and now are running low on money. They are ineligible for Medicaid. They can't afford life insurance, medical supplies or equipment, medicines, home help or anything more than a "basic" medical insurance for them both. They are near the end of their ropes and are becoming very stressed at home. They just want something that would help them have adequate care for Mrs. M. along with her staying at home.

The last area I'd like to address is the need for assistance in helping the elderly pay for prescription drugs. Most of the clients I work with at least have 5 to 8 medicines that they have to take a day. Due to the increasing life span of the individuals, many have to deal with chronic illnesses. These illnesses need care on a daily basis with medicines. I have been in houses where the clients had to decide between buying food or medicine. They will try to skip days and take no medicine one day and take it the next, to save some money, or use half the amount of medicine prescribed. I have clients on special diets but they are not able to maintain these diets because it's too expensive to get the food that they need. I have clients also unable to hire help for their home because there is no money after they pay for their medicines. AARP reports that out-of-pocket costs for drugs is $7 billion a year. I think it is real sad that the elderly are faced with the decision to either take their medicines as prescribed or to try to eat.

I think the catastrophic benefit is a much needed first step, but I would like to encourage the government to take a longer look at what the needs of the elderly are. Thank you.

Senator RIEGLE. Thank you very much. That is very helpful testimony and it's very powerful testimony.

[The prepared statement of Ms. Dillmann follows:]

WENDY DILLMANN, B.S.N., TRI-COUNTY OFFICE ON AGING, CARE MANAGEMENT, LANSING, MI

I have worked as a nurse for ten years, the last 5 of these with the elderly, generally over 65 years old. For the last 2 years I have worked in a care management program based in the Greater Lansing area. During this time I have not only worked with the elderly on medical needs, but have also become familiar with their financial needs.

Based on my own experience with the elderly, I feel the proposed legislation expanding medicare to include a catastrophic acute care benefit is a needed first step. It is very encouraging to see all the efforts being made to identify what limitations this new benefit has. There is no doubt that the elderly need help with their medical expenses; yet, it is important to look closer at these expenses to see where this help could be the most useful.

I would like to address three areas of need I have seen in working with the elderly. First is the need for education, not only with seniors, but with all age groups. It is paramount that we address the aging process and its consequences on the home, the family and the individual. We should familiarize everyone with the certainty of increasing health needs and the current means of dealing with these needs; plus, project what is ahead, if new alternatives are not started to deal with these needs.

I would ask to share with you the case of Mr. & Mrs. T. Mrs. T. has had Alzheimer's Disease for 2 years and is now coming to the stage where she requires more and more care. When we met this couple, he was fairly able to care for Mrs. T. at home. As time wore on and the care needs for his wife increased, he became more fatigued, more irritable and less understanding. His own age, 82, became a factor in his ability to provide care. As he was wearing out, he needed help in the home or somewhere Mrs. T. could go so he could be relieved of this burden. He thought, incorrectly, that he could get a room in a nursing home for Mrs. T. and have medicare pay for it. (A study by AARP shows that Mr. T. is not alone. 79% of AARP respondents polled believed incorrectly that medicare will pay for nursing home stays.) He was also unaware that due to the chronic nature of Mrs. T.'s illness, medicare will give no assistance for home care.

A second case that supports my suggestion of an added need for education is the case of Mr. and Mrs. N. Mr. N. had must retired when he was hit by his first stroke. In the next five years he suffered multiple strokes that have left him wheelchair bound and unable to care for himself. He has a chronic condition that is not improving so he no longer goes to the hospital when a stroke occurs; he receives skilled nursing for a short time following an episode. This couple had not expected what befell them. They are still paying on a home mortgage and their car. Mr. N. re-

quires tiring 24-hour care; plus, Mrs. N. must perform all of the household tasks. Mr. and Mrs. N.'s budget is very tight. There is no money left over to get help in to relieve Mrs. N. even for 1 day a week. If Mrs. N. put her husband into a nursing home, along with the emotional stress she would lose all of his income, which is the major portion of their budget. (This is very common in the elderly I visit. The woman's income being lower than her spouse's becomes a critical factor, if his is to be taken away for his nursing home placement.) Mrs. N., at the early age of 63, would likely lose all of the security she and her husband have worked to build up. She couldn't afford the house or car payments, so would lose them also. Mrs. N. believed that medicare would pay for ongoing help at home. She already had a notion that medicare wouldn't help with a nursing home, but she didn't know why.

The second area I would like to address is the need for greater expansion of the catastrophic benefit. I feel a greater majority of elderly would be helped, if the expansion could be pointed more toward improvement of benefits for those requiring long-term care. I feel this is necessary to prevent the impoverishment of the chronically ill person as well as the spouse. I am scared by figures I hear, such as: 4 out of 5 elderly (over 65) have illnesses not covered by medicare, or, 6 out of 7 people would be devastated by the cost of long-term care. I do not, however, want to play down the need for the expansion outlined in the catastrophic benefit. The elderly need the extended skilled home care days, the unlimited hospital days, no prior hospitalization to S.N.F., placement of a cap on all out-of-pocket expenses for all medicare-covered services and the extension of skilled days allowed in a S.N.F., plus the others outlined in the benefit. Yet from our experience, as well as the figures we've heard, the catastrophic benefit would help only a small percentage of the elderly. In our clients I have found the usual stay in a hospital to be 7-10 days with some extending to 30 days. (AARP reports the usual hospital stay is 7.8 days), so any extension of hospital time would not greatly affect the majority of the clients I work with. The cap on out-of-pocket expenses, as I understand it, does not include doctor charges in excess of medicare-approved fees (figures I have seen report that 3 out of 4 doctors charge more than Medicare approves). Neither does the cap help pay for eyeglasses, prescription drugs, long-term care, hearing aids, dental services or custodial care.

In the past two years I have seem many clients that need help with medical expenses. Many of these expenses are related to a chronic illness. The case of Mr. and Mrs. reflects what could happen to a couple in their early 60's, if one had an illness with long-term-care needs. Neither Mr. or Mrs. M. receives medicare as they aren't old enough. Mrs. M. had a stroke a few years ago that left her partially paralyzed and necessitated 24-hour help. Financially they have gone through all of their savings, extended their credit to the limit, sold off any sellable assets and now are running low on money. They are ineligible for medicaid. They cannot afford life insurance, medical supplies or equipment, medicines, any home help and not more than a "basic" medical insurance for them both. They are near the end of their rope and need relief that meets their need of staying together in their home with adequate care for Mrs. M.

The last area I'd like to address is the need for assistance to the elderly in paying for prescription drugs. Most of the clients I have seen take 5–8 medicines daily. Due to the increasing life span of individuals, more people are having to deal with chronic illnesses. These illnesses need to be treated daily with medicines or a dramatic decline might be experienced. I've been in houses where the client has had to make the decision to buy medicine or buy food. They will try to skip days (take no medicine) or use ½ the amount of medicine to save money. They often have to wait, if their is a new prescription needed, until their next check comes in. I have clients who are on a special diet to improve or maintain their health; yet, they admit they can't follow it because the foods are too expensive once they spend their money on their medicines. I have also had clients unable to hire help for their home because they have no money after they pay for their medicines. (AARP reports the out-of-pocket cost of drugs is 7 Billion dollars yearly.) I think it is sad that the elderly are faced with the decision to either take their medicines *as* prescribed or to eat.

I repeat, I think that the catastrophic benefit is a much needed first step, but I encourage the government to take a longer, more comprehensive look at the needs of our nation's elderly. Quality of life needs to be considered—not just keeping people alive.

Thank you for this opportunity to address the issue of catastrophic acute care benefits.

Senator RIEGLE. Mr. Ellstein.

STATEMENT OF CHARLES L. ELLSTEIN, SENIOR DIRECTOR, MICHIGAN HOSPITAL ASSOCIATION

Mr. ELLSTEIN. Thank you, Senator. On behalf of the Michigan Hospitals, I appreciate your invitation to speak on this issue of catastrohic and long term illness which is an issue of great importance to Michigan hospitals and the patients and communities they serve. We use the term catastrophic illness to convey both the personal hardship in pain and suffering caused by serious and extended illness as well as the financial catastrophe for patients and their families that may accompany such illness because the associated health care expenses are not covered by insurance or are beyond the family's ability to pay. Because the Congress is concentrating it's attention on the financial consequences of catastrophic illness, I will confine my remarks to that area but we ought not to lose sight of the other implications of catastrophic illness.

Catastrophic health care expenses results from three gaps in health insurance coverage. Number one, inadequate Medicare coverage of catastrophic acute care costs; number two, even more inadequate public and private coverage of long term care costs, and third, the presence of an estimated 35 million uninsured persons in the non-Medicare population and I will focus on all three of these areas.

The strength of the Medicare program is in its coverage of acute illness and acute in-patient care. However in it's present structure Medicare still contains many gaps in coverage for acute illness and does not protest against catastrophic financial loss associated with acute care. The confusing patchwork of deductibles, copayments, spell of illness restrictions and benefit day limitations can result in catastrophic financial loss for beneficiaries. While it is true that the number of beneficiaries who incur catastrophic expense is small, that knowledge is of little comfort to those unfortunate few. And since catastrophic illness can befall any of us, we are all at risk for the resulting financial ruin. Over the years, advances in medical technology, changing service demands, cost containment efforts and other influences have resulted in more acute care being delivered outside of the in-patient hospital setting. The Medicare benefit structure, however has not kept pace with this advance in this evolution in health care delivery. Many non-in-patient acute care services remain either not covered by Medicare or carry greater copayments burdens. The best example is one that has been talked about extensively and that is the lack of coverage for prescription drugs. Through advances in pharmacology, many patients can now receive acute care treatment in an out-patient drug therapy regimen. But such services remain uncovered and may be the source of significant, indeed catastrophic, out-of-pocket expenditures. With respect to the gaps that remain in Medicare coverage of acute illness, we would offer the following recommendations. Number one, eliminate the existing day limitation for in-patient hospital care. Number two, simplify the maze of deductibles and copayments for hospital care, physician services, and other covered services and put a cap on the liability a beneficiary may face with these copayments. And, number three, extend coverage to prescription drugs. If the Federal Government continues to promote alter-

natives to in-patients care but fails to offer protection against the cost of alternatives site and alternative therapy delivery. The practical effect is to shift the costs of care to beneficiaries themselves and other payers in the private sector.

The leading cause of catastrophic expense is, as you have noted, among Medicare beneficiaries is the almost complete absence of coverage of long term care, institutional care, associated with chronic illnesses. No other cause of catastrophic expense even comes close in the number of beneficiaries effected or the size of the expense. Our national policy for financing long term care is to require catastrophic financial ruin for patients and for their dependents in order to qualify them for Medicaid, and then to underfund Medicaid payments to providers of long term care to such an extent that access and quality of care are threatened.

Perhaps the most discouraging aspect of all are the barriers to utilizing the limited long term care services that are covered by Medicare, namely skilled nursing care facility and home health services. In the past few years, reports have increased of fiscal intermediaries applying increasingly stringent medical review criteria to deny skilled nursing facility and home health service claims. Even when benefits for skilled nursing facilities are approved, the current copayment of $65 per day for the 20th through the 100th day of service often exceeds the total per diem payment level in effect eliminating the skilled nursing benefit for all but the first 20 days of coverage.

Our recommendations in this area of long term coverage are as follows. First, meeting the staggering forecast for long term care expense requires the participation of both the public and private sectors. The Federal Government must do all it can to encourage the development and purchase of affordable private long term care insurance through tax incentives, research, and public education. Second, public programs to support long term care must adopt more humane alternatives to the current Medicaid spend-down requirements. And, third, barriers to use of existing Medicare long term care benefits must be minimized.

While discussions of the catastrophic care problem frequently focus on the dramatic but nonetheless relatively rare acute care expenses of the elderly, the catastrophic care problem extends more broadly in just as dramatically to the estimated 35 million people mainly under age 65 who are entirely uninsured. I'll not review the dimensions and nature of this much debated issue as I know you are aware of them through your efforts but I do want to impress upon you the concern of hospitals over this problem and offer some general recommendations for addressing them. First, because the public expects needed care to be provided regardless of ability to pay, participation in financing a solution to the problem must be broadly based. Proposals to keep the financing responsibility on providers who have seen their uncompensated care loads more than double over the last 5 years while public and private insurance programs seems to be reducing their commitment violate this principle and treat only the symptoms and not the cause of the problem. Secondly, efforts must be directed at reducing the number of uninsured through private insurance. We know that most uninsured people are either employed or dependents of employed per-

sons. The system that works for so many employed persons must be leveraged to work for all employed persons. At both the federal and state levels, tax policy and other regulatory incentives or disincentives can be redesigned to promote minimum coverage levels for employees and their dependents, to extend coverage for laid off workers, or to promote the development of affordable insurance products for small employers and other difficult to insure groups. And, third, public programs for those still unable to obtain private insurance must be restructured and extended to narrow the gap between their present performance and their original promise. At the federal level, funding must be stabilized and eligibility criteria reformed so that greater numbers of the non-Medicare eligible poor are covered by the program.

Before I conclude, Senator, I would like to take one moment to note and express the thanks of the Michigan Hospital Association and our hospitals for the efforts you have shown in protecting the Medicare budget during the development of the Congressional Budget Resolution this spring and I know that we can count on you to continue your efforts on the Senate Finance Committee as you consider specific proposals which will come before it during Budget Reconciliation.

Thank you for the opportunity to speak today and please call on the Michigan Hospital Association in any way we can be of assistance on this subject and these issues as they progress through the Congress.

Senator RIEGLE. Thank you very much and I appreciate that comprehensive set of recommendations. They will be helpful to us.

Dr. O'Brien.

STATEMENT OF DR. JAMES G. O'BRIEN

Dr. O'BRIEN. Thank you, Senator Riegle. As a physician who provides care and as an educator I have obviously a major interest in addressing this problem. Rather than provide a lot of solutions which certainly go beyond my scope I really want to provide a context in which the problem can be viewed. Many of the devastating and chronic illnesses are clustered in the elderly population. With the rapid growth of this segment of our society and particularly of the more frail elderly, namely those over 80, this problem has become much more accentuated.

Despite the fact that most of the elderly are healthy and free of a major disability, a significant percentage experience some limitation of activity as a result of chronic illness. The World Health Organization has suggested that health in the elderely is best measured in terms of function rather than the presence of disease. Thus, even though presently a person of 65 can expect to live for an additional 16 years, probably only the first 10 years of the time will be free of disability. In the remaining 6 years it is likely that person will be dependent in some manner as a result of chronic illness. The first 10 years of this cycle is referred to the active life expectancy.

Health care services that best meet the needs of the elderly should extend the period of active life expectancy and lessen, whenever possible, the disabilities associated with advanced aging and

disease. Our current system of care is ill-equipped to respond to this challenge. Our system is based on an acute care model that attempts to respond to the disabled elderly in a fragmented fashion. This phenomenon exacts a significant toll on the elderly and their families. Present insurance reimbursement schemes fail to cover many of the services necessary to maintain and restore health such as in-home care, nursing home care, and the cost of medications for treatment of chronic illness. What has evolved is a system of provision of care that attempts to meet the different needs of the disabled elderly with a system that is geared exclusively to provide acute care, such as with the introduction of DRG's which are biased in particular against the elderly who may need additional time to recover from an illness.

I want to give just one example. Probably no problem better characterizes the plight of the elderly than the problem of dementia including Alzheimers disease. In Michigan, by the year 1990, unless a care is found, as many as 214,000 Michiganians will suffer from dementia. I would suggest that perhaps the recommendations developed by the State Task Force that Governor Blanchard convened and which I served on, be viewed. I think these proposals certainly highlight some of the problems and perhaps some of the solutions.

So in closing, currently the social, economic, emotional, and physical burdens of meeting the gaps in the present system fall on our elderly patients and their families. This problem requires your urgent and informed attention, Senator Riegle. Thank you.

Senator RIEGLE. Thank you, Dr. O'Brien. I really appreciate the testimony of both panels. It's comprehensive and a great help to us. We have got now approximately 30 or so other individuals who have asked to speak and we are going to commerce with those individuals at this time. I want to excuse the panelists who are welcome to stay if they wish but will not need to remain at those tables unless they so wish. State Senator Mitch Irwin has asked to make a comment. Mitch, why don't you take the microphone. You will be followed by Alona Fritts, by Clarice Jones, and then by Dr. George Gomez.

STATEMENT OF MITCH IRWIN, MICHIGAN STATE SENATOR

Senator IRWIN. Well thank you, Senator Riegle. I am going to do two things this morning. Number one, I would like to be the guinea pig so all of you can see how we will work this drill. When you come up we would like to ask you to state your name and your address or at least where you are from and speak directly into the mike. If it needs to be moved just ask for some help. Our people will be glad to do that.

Secondly, I would like, Senator Riegle, to express to you and our friends in the audience today our greeting from the Michigan legislature. My name is Mitch Irwin. I represent the upper peninsula and northern lower Michigan in the State senate. If you have ever been to Escanaba, Sault Ste Marie, or Traverse City you're in God's country and that's my home area. So I am here to greet you on behalf of the Michigan legislature where we look with great support and a great deal of attention to the efforts underway today in

improving our catastrophic health care coverage for our elderly citizens in Michigan. I want to say to you that there's one particular thing that you folks should be aware of. We have heard the stories and will continue to, and I think that all of us who serve on the Joint Committee on Aging in the Michigan legislature have through the hearings heard of the cases in which people have had to make some very difficult, painful and unhealthy decisions on the choice of whether they're going to spend their dollars on health care costs or on prescription drugs or on simple shelter, heat and electricity. And we know that a health care system without catastrophic coverage is just not what our seniors deserve and we are going to continue to support work towards a catastrophic program.

I'd like to point out in any attempt to address this tragic situation we have to include the cap on out-of-pocket expenses, we have to include home health care coverage, and we have to include coverage for the other catastrophic illnesses that are not included in the Reagan-Bowen plan and that includes the Alzheimer's, Parkinson's disease and others. I think that on the State level, what I'd like to share with you today is this; we are working, as many of you know who are working with us, on improving the quality and the affordability of health care. We are working on House Bill 4141 which is a prescription drug program for seniors. I co-sponsored that bill and am going to continue to work every hard and hope to achieve that goal. With your help we have adopted a Medicare supplemental insurance reform act which I proudly sponsored and worked with you and that will compliment the effort that Senator Riegle is pushing for—a Federal catastrophic program. But, I think it is important that we in the State let you know, Senator, that we are going to be very, very aware and follow very closely the issue and that if there is a cost savings to the State Medicaid program as a result of this effort, we are going to see to it that is expended on other needed enhancements and improvements to the health care delivery program for our State citizens. I think that should be said here this morning loud and clear.

I'd like to say lastly that it's not only clear that we need a catastrophic health care program, it is cost efficient. But it is also morally right. And it is also clear from this testimony that which we've heard throughout this State that the need is now. And I want to commend you on behalf of my colleagues in the Michigan Senate and pledge our continued cooperation and support to your efforts, Senator, and thank you very much.

Senator RIEGLE. Thank you Senator Irwin. We appreciate the leadership you are giving at the State level and we approciate that report from State government officials.

Now Alona Fritts. She is coming up here to this front table. We will put the microphone as close to you as we can so that you can be heard throughout the room.

STATEMENT OF ALONA FRITTS, DIMONDALE, MI

Mrs. FRITTS. My name is Alona Fritts. I live in Dimondale. I have Guillain-Barre syndrome. It's an illness similar to polio that comes on you very suddenly. I was a very active person. Within 4 days of my first onset of it, it made me completely paralyzed from my neck

down. I was in intensive care. I had complete life support system. I have had a trach in my throat which spoiled by singing voice forever. But I am able to talk now. I was 9 months and 10 days in the hospital and I was put in a private room because the doctors felt that I needed that. And up until 2 months before I was released from the hospital, I needed to have nursing care because I had to have shots everyday to prevent blood clots because I was not able to move at all.

At that time I was getting very restless at being in the hospital. I was in therapy every day and learning to stand again, learning to speak again, all of the other good stuff that you lose when you are paralyzed. I asked to be released from the hospital and my daughter, Mrs. Gibson, who is here with me went to all sorts of places to see whether or not we could get help because Medicare was paying $500 a day for my hospital care but there was no place that would help with in-home care.

I was paying $100 a day for someone to be with me for 5 days of the week. My children took me on weekends. Over a period of time it cost me $14,000 to have this care. I still have to have in-home care and it will be 2 years in August since this came upon me. I am getting better and I hope eventually I will get fairly normal. I am still having therapy to try to get my crippled hands to work again and I am still in braces for my legs. But I do feel that since Medicare was willing and I had no problems with insurance I am still getting bills from the hospital yet. But, I hope that eventually insurances that my husband had through General Motors will take care of it. But, if they would have paid anywhere near what the hospital bill was, which was $500 a day, for when I got home I think this would be a benefit. I am very fortunate because of the insurance through General Motors that my husband did have but, there was no insurance that would cover in home care.

Senator RIEGLE. I appreciate your coming today and telling us this. Now you highlight another issue here that is, you were one of the fortunate people in terms of coverage that your husband had this supplementary——

Mrs. FRITTS. Blue Cross/Blue Shield.

Senator RIEGLE. Blue Cross/Blue Shield through General Motors.

Mrs. FRITTS. General Motors, right.

Senator RIEGLE. And that's something, of course, in our State a lot of the UAW workers fought hard to get that kind of coverage so that was available to General Motors or automobile company employees.

Mrs. FRITTS. And as his survivor, it has continued.

Senator RIEGLE. But most people of course don't have that.

Mrs. FRITTS. That's true.

Senator RIEGLE. So they would exhaust the Medicare limits unless they had a Medigap policy or private insurance policy they would have been hit. Now you were paying $500 a day. Didn't I understand you to say that you were in the hospital for 9 months?

Mrs. FRITTS. Nine months and 10 days.

Senator RIEGLE. Now, let's just do the mathematics on that, that's at least 270 days. So that's $135,000.

Mrs. FRITTS. I have in my purse right now a statement from the hospital stating that it was $138,000 of which I should pay $4,000.

Senator RIEGLE. That's because you had that supplementary insurance.

Mrs. FRITTS. That's right.

Senator RIEGLE. But if somebody else out here that didn't have that got hit with that bill, they would have to pay most of that.

Mrs. FRITTS. That's true.

Senator RIEGLE. I think another thing you've said that's so important is that this came on without any warning.

Mrs. FRITTS. Absolutely none.

Senator RIEGLE. You were living a normal life. Bang, you got sick. Four days later you are completely paralyzed.

Mrs. FRITTS. That's true.

Senator RIEGLE. You were in the hospital and before your were able to leave the hospital you have run up $138,000 just in hospital bills.

Mrs. FRITTS. That's true.

Senator RIEGLE. Then you would have had medical bills from doctors over and beyond that.

Mrs. FRITTS. The therapy bill was over $125,000.

Senator RIEGLE. In addition?

Mrs. FRITTS. In addition. This is just for hospital care.

Senator RIEGLE. So that's another $125,000 for therapy and what about other things?

Mrs. FRITTS. And the doctors bills were probably around $5,000.

Senator RIEGLE. So that's over a quarter of a million dollars.

Mrs. FRITTS. That's true.

Senator RIEGLE. Without any warning.

Mrs. FRITTS. There certainly wasn't.

Senator RIEGLE. Thank God in your case you had the private insurance.

Mrs. FRITTS. Without that—and my husband 2 years previously had cancer and he was in the hospital off and on for over 2 years and his hospital bill was more than $150,000 which was covered not completely. We still had to pay quite few—part—of the doctor bills

Senator RIEGLE. I think a lot of people are here today because they have seen situations like this. Some have experienced situations like this themselves. All of us have to worry about this kind of thing happening in our families and I think we ought to be worried about it happening in the family next door or down the street or across town. I don't think it is enough just to worry about ourselves.

Let me say I admire very much your courage and your willingness to come today and give us this personal testimony.

Mrs. FRITTS. If it will help in any way I am all for it.

Senator RIEGLE. It helps in a big way and we thank you very much for coming.

Mrs. FRITTS. Thank you.

[The prepared statement of Mrs. Fritts follows:]

STATEMENT OF ALONA FRITTS, DIMONDALE, MI

The following is a summary of Mrs. Alona Fritts's forthcoming testimony to be presented at Senator Riegle's Public Hearing which will be held on June 29, 1987. The topic of this hearing is the catastrophic Medicare bill which is now pending in

Congress. This summary was prepared by the staff at the Tri-County Office on Aging.

Alona Fritts is a 69 years old woman who resides at 305 E. Washington, Dimondale Michigan 48821. Mrs. Fritts is providing this testimony in the hope that her story will help others who are faced with similar unfortunate events which one encounters during and following a catastrophic illness. Here follows a summary of her testimony as told to the staff at TCOA:

Mrs. Fritts had been a very active citizen in the community and had enjoyed good health. Her husband of over 40 years developed cancer in 1982 and Mrs. fritts was his caregiver around the clock for the last two years of his life, desiring to keep him at home rather than placing him in a nursing home. As a result of his illness, their finances were gradually depleting due to the various hospital and home care costs they encountered which were not covered by Medicare. Mr. Fritts was a GM retiree and had good Medicare supplemental insurance as a benefit from GM. However, they still incurred medical bills which were not covered by either Medicare or their supplemental insurance. Mr. Fritts passed away in September 1984.

In August of 1985, Mrs. Fritts became critically ill with a debilitating condition known as Guillain-Barre, a immunological attack on the peripheral nerves. The extent of her condition was very serious in that she suffered extensive residual effects including paralysis from the head down. She was only able to move her head but was unable to speak. Mrs. Fritts was in Critical Care in the hospital for over nine months and during this period she underwent several life sustaining treatments including a complicated procedure where plasma is removed and replaced with normal plasma. Catheters were also inserted in her chest and groin, she was fed intraveniously and had a tracheotomy for over six months. She had extensive residual effects from this disease.

Mrs. Fritts's condition did improve to a point where she could speak (although it was very difficult) and receive physical therapy but she was very determined to overcome this disease. Although still unable to communicate well or walk, Mrs. Fritts's physician felt (along with the family) that she would improve better out of the hospital environment. Nine months is a long time to spend in the hospital and they felt, as did Mrs. Fritts, it would benefit her condition if she went home. Mrs. Fritts maintains that she was becoming depressed which in turn was affecting her physical condition and going home was a positive experience. Her home was inspected by the physical therapy staff to determine if it was conducive to the physical environment she required. Specific alterations were completed which made her home safe and barrier-free including a ramp and intercom system for safety purposes. Mrs. Fritts was discharged from the hospital on May 19, 1986.

Mrs. Fritts required 24 hour care at home and needed assistance with eating, transferring, mobility, bathing, physical therapy both in and out of the home, supervision, health monitoring and special transportation to frequent doctor visits (which she still requires). The 24 hour care required a skilled person and Mrs. Fritts had this live-in care for seven months. Her family was also very supportive and continues to assist her with things that do not require the services of a skilled person.

While a nursing home placement was an option at her hospital discharge, Mrs. Fritts elected to go home, feeling that she would improve better in her own surroundings (she has lived in her home since she was married and her family was close by). Had she chose to enter a nursing home, the cost of the care would have been covered by Medicare for as long as she met the eligibility criteria for skilled care. The estimated costs of this type of care would have been around $3000 per month and the cost of the hospital room she occupied was $500 a day. However, Mrs. Fritts's choice cost her financially, even though she maintains that she improved much better at home. The total cost for the 24 hour care at home amounted to over $12,000 and she is still paying the balance. These charges were not covered by Medicare even though they were less than Medicare reimbursable costs such as a skilled nursing home or inpatient hospital charges. The aggregate cost of her hospital stay was over $200,000 (covered by Medicare and insurance for the most part).

Her home care costs were not the only non-covered medical services Mrs. Fritts had to pay. She also incurred over $2000 in doctor and medical supplies which Medicare and her supplemental insurance either did not cover at all or only in part. Many of these bills were incurred while she was in the hospital.

As a result of this catastrophic illness, Mrs. Fritts was saddled with over $14,000 in uncovered medical bills. She states that she received excellent care and still maintains that others are "worse off than me". She hopes that the Medicare system can be improved so that others who are faced catastrophic type illnesses will fare better than she. In her own words, "I hope that my testimony can help others and if I can make some small contribution, I am more than happy to do so."

Senator RIEGLE. Clarice Jones. Then we have two doctors that have been kind enough to come in on a work day to testify as well. Dr. Gomez and Dr. Granse. Are they both here? If you would like to come on down here we will take the two of your next. You will be followed by Keith McCall. Now, Clarice. Thank you for coming.

STATEMENT OF CLARICE JONES, AMERICAN ASSOCIATION OF RETIRED PERSONS (AARP)

Ms. JONES. Well thank you Senator Riegle for being here and for giving us the opportunity to express ourselves and in your support. I bring from AARP, the organization for which I represent, a message of appreciation for your support in areas of Social Security as well as your efforts in this particular area of catastrophic insurance. And also I am grateful to be able to state the Association's views on the problem of catastrophic illness. The Association commends you Senator and your colleagues for your work towards the development of catastrophic health protection for the American public.

Our written statement for the record contains a comprehensive discussion of the major source of catastrophic cost for older Americans, the cost of long term chronic illness. The statement further chronicles the older person's acute care catastrophic experience including an analysis of current Medicare coverage and beneficiary liability for coinsurance and for non-covered services. We also describe the coverage provided by Medicare supplemental insurance, known as Medigap and the rule of Medicaid in providing a total picture of existing coverage and vulnerabilities to catastrophic expense. We set forth in detail both the provisions in Secretary Bowen's catastrophic proposal and those in the bill recently approved by the Senate Finance Committee. The bill by the Senate Finance Committee is an improvement over the Administration's plan. It provides a lower cap and greater benefits bridging the gap between acute and long term care. The bill does not currently contain a prescription drug benefit but the committee has indicated its intent to develop one.

The Association advocates the development of a benefit improvement that incorporates a catastrophic cap but is more compenhensive than either the Administration or the current Finance Committee plan. Our proposal better balances the need for acute care protection with a need for a long term care protection. It also includes critical protections for low income beneficiaries.

The elements for which AARP consider integral to a meaningful plan that could be passed by this Congress are also set forth in detail in our written statement. The Senate Finance Committee has already adopted several elements of our proposal. Today I would like to focus on some critical benefits that are not yet adequately addressed in the Senate bill. The Senate bill does not yet have a meaningful prescription drug component, it includes no respite care provision and it forces an unacceptable choice of either providing catastrophic coverage to Medicaid health beneficiaries or

protecting persons from impoverishment when their spouses are institutionalized in nursing homes.

In order to have a catastrophic protection law that affords meaningful protections to majority of Medicare and Medicaid beneficiaries, AARP urges that at a minimum the Finance Committee bill be amended as follows. One, provide a prescription drug benefit that covers all medications, not just immunosuppressants which benefits few. A benefit with a $400 deductible will provide relief to the majority of older persons who expend large sums on life sustaining medications to control chronic conditions of aging.

Two, include a respite care provision to provide the temporary relief which enables the family and volunteer care givers to continue providing care in the home to persons who would otherwise be institutionalized. I think you have heard a great deal about that today and some of which I think stired many of us to tears.

Three, the bill must not put protections for spouses against coverage for low income beneficiaries. Both are essential components of catastrophic protection targeted at different but equally needy populations. A humane catastrophic bill must include both protections.

Finally, we must say a word about the proposed method of financing. Although we find this two tiered premium system less onerous than alternative proposals to tax the actuarial value of Medicare coverage, it is not AARP preferred financing mechanism. We encourage Congress to seriously consider AARP's financing proposal. Including all State local and employees in Medicare and increasing the tobacco tax are both equitable options which would contribute substantially to the financing of catastrophic benefits. If these options were taken, along with the minimal flat premium on all beneficiaries there would be no need to move into the uncharted terroritory of supplemental premiums. It's such a confusing area anyway.

In conclusion we are encouraged by the progress that has been made thus far this year and are hopeful that these efforts will result in a meaningful catastrophic benefit. Thank you for the opportunity.

Senator RIEGLE. Thank you very much for that very well focused testimony. We will make the full statement a part of the record.[1] Thank you very much. Dr. Gomez will be followed by Dr. Granse to be followed by Keith McCall, Mary Ellen McCloy and Mabel Cline.

STATEMENT OF DR. GEORGE GOMEZ

Dr. GOMEZ. Thank you Senator. My name is George Gomez, I have been practicing in Michigan for the last 20 years. I appreciate your efforts to provide medical care for the people, especially the elderly, in Michigan. I strongly support that.

As I pointed out to you in a letter that I delivered to your office about 2 weeks ago in Washington, we are having a problem that has not been an issue here and that is retaining physicians in the State of Michigan. During the last several years there has been an exodus of physicians leaving the State, going to another State or

[1] See p. 135.

retiring early. There are several reasons and I would like to point them out to you.

The main one is malpractice premiums that have to be paid. Nothing has been done to improve the situation. Total reform was passed in 1986 and provided nothing but an increase of 15% in our premiums. It's coming to a point that we can not afford to pay that. We are spending more money in malpractice than we spend in clothing and food. There are premiums between $25 and $70 thousand a year that have to be paid and we never get them back. This is one problem that has to be addressed and I don't think can be addressed at the State level. The Federal Government has to do something to stop that. We talk about the outragious cost of hospital care. Malpractice has some to do with that. The fees of the hospitals and the doctors has to go up in order to pay for these premiums.

Another issue that make physicians leave the State and go somewhere else or retire early is that here in Michigan we have the lowest reimbursement than any other State in the midwest. These issues plus the cost containment from the hospitals that make us discharge patients earlier is effecting the quality of the care and that make physicians get tired. And they cannot practice this way anymore.

So I think I agree strongly with your efforts. I think the people of Michigan, especially the elderly should have health care provided someway—Federal, State, anybody. I agree with that. But I think that the health providers have to have some help and I appreciate your efforts and I know that you can do something about it. Thank you very much.

Senator RIEGLE. Thank you for coming today and for making those points. Those are important points, I heard an illustration the other day of an obstetrician whose liability insurance against malpractice premium was like $44,000 a year and that doctor delivered something like a 120 babies in the course of the year. He had figured out—I don't remember the precise numbers—but it was like $300 or so per child delivered was the cost of just the malpractice insurance that that doctor was paying in a given year. I know a number of doctors, as you say that are leaving medicine early—some are leaving the State—because they see other States where the situation is somewhat better. Buit there are a lot of others that are retiring early because they feel that the difficulty of charging enough to be able to earn back the malpractice insurance premium is just too difficult. You make an important contribution today. I appreciate your testimony.

Dr. GOMEZ. Thank you, Senator.

Senator RIEGLE. Thank you. Now Dr. Granse will be followed by Keith McCall, Mary Ellen McCloy, Mabel Cline, Jim Church, then Mr. Wolverton.

STATEMENT OF DR. RICHARD GRANSE

Dr. GRANSE. Thank you my name is Dr. Richard Granse. I practice internal medicine here in Lansing. This is actually more closely related to catastrophic health care than I thought it probably

would be. But I just want to tell you briefly about one case that I had, one patient that I took care of.

As you know the Peer Review Organization reviews all the Medicare admissions in the hospital throughout the country and we are no exception. The particular patient in question was an approximately 83 year old man who had severe chronic lung disease. He had severe congestive heart failure, high blood pressure which was difficult to control, and ultimately, kidney failure. I took care of this gentleman for approximately the last 7 to 8 years of his life and the last two of those he had approximately 4 to 5 admissions to the hospital. He had been on the ventilator on at least one occasion.

Finally, after considerable discussion with him and his wife we decided jointly that we wouldn't try any more heroic measures to resuscitate him or put him on respirator or bring him back if he should have a cardiac arrest. This was done with his full consent and knowledge. He than was transferred to a basic care nursing home when his wife could no longer take care of him and I saw him as often as necessary there.

One day he developed increasing shortness of breath and essentially went into acute heart failure or acute pulmonary edema. I was able to get to the nursing home about 10 o'clock that night. The patient himself was really unable to communicate with me at that time. His blood pressure was quite low, in the range of 70 to 80, and he was sitting up gasping for breath.

I called for his wife and we talked the situation over and I explained to her what could be done in the hospital for him to make him more comfortable verses what could be done at the basic care nursing home. It was a decision of the wife that he be transferred to the hospital to make him comfortable. Specific things were done there that could not be done at the nursing home. He was able to get a higher concentration of oxygen, he was able to be given more respiratory treatments. Really, they could not give him any at all at the basic care facility. These weren't a respirator but they were inhalation treatments that would help expand his lungs. We had the capability in the hospital of giving him I.V. medications such as diuretics to try to get some of the fluids off his lungs and to give him some I.V. morphine. All of these things he received.

I believe in my heart and his wife believes the same thing that it made him more comfortable. Approximately 18 hours after admission he expired. We found out more than a year later that this admission was denied by the PRO and we appealed that. And we lost the appeal and really nothing will make the point more clear than to read you what the reviewing nurse from the PRO had to say. What she said was that this patient is terminal treatment of pulmonary edema, in other words acute heart failure—could have been done in the ECF. Death was not unexpected. Intensity of service not met. Very terse comments and, I might add, that this was not an extended care facility. It was a basic care nursing facility and there is considerable difference.

Our reviewer from the hospital where I practice had a very nice response which, as I mention, was turned down and she concluded by saying death may have been expected but it seems inhuman not to respond with treatment to relieve this poor unfortunate pa-

tient's distress while in the process of dying. I think that says it very well. Thank you very much, Senator.

Senator RIEGLE. I appreciate your sharing that story with us. You know, there are some people around that I think would throw people out in a snow bank to die. I mean I think there are some people around whose attitude is that way as long as it isn't them. Usually the people that have that view are well situated, have a lot of money and a lot of coverage. They know it's never going to happen to them so they get very hard-boiled about the poor person who is in that situation. We've heard testimony earlier today about some of these requirements to get people out of the hospital faster whether they are really ready to leave or not. And I would guess that some serious situations have developed as a result—people who have gotten sick again and not have made it or had to go back in for complications of one kind or another. But your story helps us think about the question of who would we, as a society, and what we want to try to do. How do we want our health care system to work? We are a democracy and this is America and we can decide how we want it. And if we don't like the way it is, we can change it, make it different. We can make it better. Now obviously we have to pay for it, but we spend a lot of money for a lot of things. You know we have been buying $600 toilet seats at the Pentagon and $800 coffee pots.

But we must decide, it seems to me, as a society what we want to do in the health care area and that's why getting these facts out in the open is no important. And it means a lot to me, that as a practicing physician you would take the time today to come and wait for an occasion to speak in order to put this story on the record so that we can start to make sense of where we are and what we want to try to do together as a humane people. I thank you very much for coming and I am glad you are a doctor.

Dr. GRANSE. Thank you, Senator Riegle.

Senator RIEGLE. Mr. McCall.

STATEMENT OF KEITH McCALL, DIRECTOR, COALITION OF AGING ORGANIZATIONS, AND ON BEHALF OF THE MICHIGAN SENIOR CITIZENS ADVOCATES

Mr. MCCALL. Good morning. Thank you for this opportunity to speak. My name is Keith McCall and I am speaking to you today in a dual role first, as the Director of the Coalition of Aging Organizations and also as the designated spokesperson for the Michigan Senior Advocates Council and I hasten to add that I am here as an advocate. I certainly would give credit as you did to these others that are suffering the problems. I am here to speak in their behalf but, fortunately have not had that type of tragedy.

First of all I like to mention to you the memorial held yesterday in Ann Arbor to Wilbur Cohen, that great statesmen from Michigan, who many claim is the great architect of Social Security and Medicare. Our coalition adopted the resolution honoring his life and contributions that was part of that service. And we certainly should all be proud of that man and what a crucial role he had first in creating and then secondly—perhaps in a sense more im-

portantly—throughout his life preserving Social Security and Medicare.

I like to make six points. I think you have the testimony. It's just two pages and if you want to interrupt—I mean if that's too long just say so because you do have it. But I think there is a educational element in this and I hope there is time.

First—I have six points. My comments build first of all on the important premise that we must view as reality that Medicare with all it faults is fundamentally national health insurance for the elderly and of course for selected others as well. It's important to say this first and clearly because it helps define what we believe to be the proper way to go from here.

We are sitting today in the setting of Michigan's famous Senior Power Day where in this very room just 7 weeks ago seniors from all over Michigan spoke out. Michigan seniors believe that we can provide something unique to these discussions and that is the basis for today as well and that is to provide memory. Our memory of Social Security and Medicare; what it was conceived to be, what it is today and how to hold them to the original precepts on which they were founded. Although these two are closely related, under the time constraints, I will speak only of Medicare.

Second point, Medicare must return to the insurance concept as intended in its creation in 1965. This means that it should be supported as fully as possible by premiums paid by all enrollees thereby reducing the need for—and hopefully even eliminating in time—copayments and deductibles. We don't believe that copays truly hold down the cost by deterring over-utilization which is the principle, some say, why it's there. Indeed we believe that the program should not depend on copayments and deductibles because it places that extra burden on the person who, although insured, is unfortunate enough to become ill and require the health care services.

The third point. Although we want to move Medicare back on track as we would say as an insurance program, we must equally recognize the importance of keeping everyone in the program which means that we have the ultimate community pool. Literally everyone who is 65 years of age and older and everyone who is paying the premiums and for those too poor to pay the premium—those who theoretically would be eligible for Medicaid—society, we could argue whether it's Federal Government or local, should pay that Medicare premium for the important reason to keep everyone in the system.

And I would just point out that if the program was made more complete in its coverage, just think of the savings when it is no longer necessary to spend any money to determine who is eligible for what.

The fourth point has been well discussed here. Prescription drug coverage is an important Medicare component that is there now that should no longer be limited to the hospitalization period. It is well established that prescription drug expenditures are very cost effective. The impact of prescription drug therapy on total health care costs has often been overlooked because it only accounts for 6½% of the total cost and it's coming down. It was 13.7% of the total in 1960. Of course the unfortunate side to that is that the

costs are there, the cost of drugs is going up, but it's the horrendous increase in the other phase that has brought the relative percentage down.

Drug therapy often provides a faster and safer return to health and a productive life, saving dollars by greatly shortening or in some instances eliminating the need for hospitalization and even eliminating the need for surgery.

With the public health reality that we as a society live longer a number of us face chronic disease which by definition is incurable but with proper prescriptive drug regimens that disease can be controlled so that illness is minimized. That, in our definition, is secondary prevention and is very cost effective. We are delighted that both the House Ways and Means Committee and the Energy and Commerce Committee are actively promoting a plan for Medicare to help pay. And we would suggest that the Senate should follow that lead.

The fifth point is on catastrophic. It has had a lot of play in the media recently and properly I might add. We give due credit to Secretary Bowen as others have this morning for his initiative this year. But we say as others have that we can and should do more than he has proposed.

It is important to limit out-of-pocket hospital and physician payments to a realistic level—probably not more than $1 thousand but we don't know the most current number—and provide full Medicare coverage of hospital days as necessary. We see no reason to increase the number of days of skilled nursing care provided since the national average of use is far below the present coverage but we do want to see the copayment feature removed. I acknowledge what Hollis Trunham said. I am not trying—there are problems. You have to fight to even get your first 20 days.

As others have mentioned, the far greater burden faced by the elderly—presently uncovered—is long term care, the real catastrophe. This need largely custodial, is not medical care per se, therefore, presently at least, outside the Medicare coverage.

We are disturbed by developments such as the current discussion within the Federal task force on long term care health policies which, although pointing to the importance of insurance as the answer, never the less seems to be saying that since insurance is a State regulated function then leave it to States. This path may be tempting to some but we say we shouldn't be trapped in it. Rather, long term care insurance is the next major component to be addressed by the Medicare insurance program so that we can take advantage of already having the ultimate pool of people. There can be no adverse selection because we are all in it. There is no cost for selling it and we continue to enjoy a masterful program with relatively, very low administrative cost. So if the reality is we can't do it this year we certainly should address it next year.

The sixth and final point is the principle of new benefits, and I know I disagree with some of my colleagues here in the AARP. The principle of new benefits, paid by new premiums, paid by all that are adequate and that will be income-related we feel is appropriate. Some say this introduced means testing which they abhore. However, this is not means testing since assets are not to be taken into consideration. To their credit the House Ways and Means Commit-

tee at least has rejected the original proposal to finance Medicare changes in part by taxing the actuarial value. That was a stupid idea and has been thrown out. We are greatful for that.

We know that these issues will make for tough decisions by Congress. Congress must stop the practice of holding down premiums because it is politically attractive, leading as it has, to the present unfair and uninequitable burden placed upon the sick in the manner of copayments and deductibles. If we reorient ourselves to the principle that Medicare is and was meant to be insurance, as Congress seems to be doing this session, then we are encouraged to believe that fairness will return and that all enrollees who all share the risk of becoming ill will pay a premium that is adequate to pay the benefits that be claimed only by those unfortunate enough to become ill.

We should avoid any increase in use of general revenues for Medicare. Indeed we are certainly indebted to Wilbur Cohen and others for this principle. The complete self-financing of Social Security is what, in fact, has protected that program from much greater benefit cuts during the times of government retrenchment.

And in regard to Medicare benefits, when one becomes ill we should not discriminate against anyone, either the poor or the rich. With the principle of having an income-related premium introduced for these proposed changes—these are new benefits—and particularly for these new benefits such as prescription drug coverage which were not part of our earlier payments into the system, at least we are willing to accept this principle that for a premium to begin at age 65, making it income related is acceptable since it's only fair and consistent with other principles that in fact have been part of the system such as taxing some of the Social Security benefits for upper income people, which represents the part the employer payed in the first place. And from it's inception the whole idea of Part A, where people with higher wages did pay more than others for the same fixed percentage of an insurance benefit. Thank you very much.

Senator RIEGLE. Thank you, I appreciate the detail you have given us. I want to say two things. One, Wilbur Cohen was truly a giant and he is very much missed, although in a sense he is here today because this is exactly the kind of thing that he would be part of and want to see happening. He has given us all a lot of inspiration and a big shove foreward. I think we feel him even now pushing ahead.

Secondly, I want to make a different point to everybody in the room and that is if you are of the mind that we need to do more in the health care area, in the manner in which we have been describing today, we need a political concensus to do that. That's the way this country works. We can have problems but unless we decide as a nation on a broad basis that we want to do something about it, the problem can be there and you won't see much action.

I think all of you, if you feel that way, have to become advocates. I am not saying if you don't believe it, say you do. But I am saying if you think something ought to happen, then carry that idea to others. You have to talk to your kids about it, your neighbors, your friends, your associates, people that are in your church, your social circle, for those of you who are working, people you work with and

so forth. We're not going to move ahead until there is enough of a grass roots push to make something happen.

And I say that not just with respect to our State, because I happen to obviously feel very strongly about it and I am determined to move ahead. I think the need is there. But we need to develop a broad political concensus for action so we get the message throughout our Government. It's going to take activism by each one of you. You must not feel that there is no role to play. Each of you have a role to play if you want to see something done and the more you talk and the more you advocate something you believe in, the faster you are going to see some action take place.

Mary Ellen, we would be pleased to hear from you now followed by Mabel Cline, Jim Church, Jim Wolverton and Peggy Hinchey.

STATEMENT OF MARY ELLEN McCLOY

Ms. McCLOY. I believe that any discussion of catastrophic health care should begin with an understanding of the present structure, that is, what occurs while a patient remains in the acute care setting. The current system, designed to keep health care cost down, does not truly consider the emotional and financial impact thrust upon a patient already ill.

As already mentioned this morning by others, the prospective payment system has had certain undeniable results. The allegations of patients being sent home quicker and sicker is one that can't be avoided. In my mind the catastrophe actually begins during the final days of an acute illness and strikes at both the patient and the hospital. If you ask how hospitals are affected, Federal policy dictates that the provision of only acute care occur in the hospital and at the same time accuses hospitals of prematurely discharging patients.

Recognizing the vulnerability of the fragile elderly, many hospitals are assuming the cost of the final few days of hospitalization in order to provide stability. This provision of care without reimbursement will lead to financial problems and ultimately the closing of many hospitals. As hospitals are forced to close their doors, access to health care will become increasingly limited and these limitations will then lead to the rationing of health care, a situation which I believe challenges all our basic assumptions that we all have a right to good medical care.

While it's an acknowledged goal of the prospective payment system to eliminate what they perceive as an excessive number of hospital beds this goal seems ludicrous as the elderly population will continue to increase with the aging of baby boom generation.

How is the patient affected? Each recovering patient is potentially in financial danger. By definition, he is no longer acutely ill but is certainly not yet well. An elderly spouse who takes her loved one home finds out that they have neither the strength nor the financial ability to provide necessary care. Should the decision be reached that the patient requires care in a nursing home, most families are shocked to find that unless the care is authorized as skilled, it will not be covered by either Medicare or their secondary insurance.

Please note that a survey of nursing home personnel will reveal that what is now considered a skilled patient is much sicker than in the past. Therefore it follows what we now call a basic or custodial care patient is also more sick than in the past, and the care needed cannot reasonably be provided by the family members at home.

The cost of basic care is not covered by Medicare and only about 2% of existing private insurance companies will pay for this level of care.

In addition to the lack of insurance coverage for catastrophic care a further insult now presents to the elderly in the form of insurance scams, I think we have all heard of, that leave the senior to spend their money buying coverage that will not protect them because there are so many exclusions and qualifications in the policy that their claims end up not valid.

In summary, these are only the most obvious problems that could be alleviated by a catastrophic health care plan. Not mentioned of course are cost of prescriptions, dental care and eye glasses already mentioned this morning also.

Since finance is not my field of expertise I can't truly evaluate the proposed method of funding, however I am concerned that after senior citizens opt for higher premiums they will once again find themselves enmeshed in a system with so many rigid controls and a government out of funds. This expansion of benefits without financial resources is what has led to the present problems. It would seem like the time has come to insist the private business sector assume greater responsibility in assuring health benefits to their retired employees.

Senator RIEGLE. Thank you Mary Ellen. That's a very find statement and I appreciate your coming and waiting so long to be able to make it. It's helpful to us. Mable Cline. Some people I know will feel that others have said what they are going to say so they will not remain.

STATEMENT OF DR. McELMURRAY ON BEHALF OF MABLE CLINE

Dr. MCELMURRAY. I can tell you what she was going to say with regards to MPRO. I am Dr. McElmurray and I asked her to come. She had testified before the hearing of the State in regards to evaluations of MPRO. She has bad arthritis and she was here earlier and had to leave because of poor health.

Senator RIEGLE. I see.

Dr. MCELMURRAY. To make a long story short, she had been admitted to the hospital. Her arthritis had worsened and the family decided one night she simply had to be taken to the hospital. She couldn't walk and couldn't get around the house and provide for herself. They had her in a wheelchair and were transferring her from the wheelchair to the car and she slipped and fell to the ground in the snow. They were unable to get her into the car and they had to call the paramedics and she was taken to the emergency room in the Ingham Medical Hospital.

X-rays suggested that she may have fractured her hip. She was in severe pain and she was admitted to the hospital and discharged

about 3 days later after the x-ray studies showed that she had not fractured her hip and after her pain had been controlled.

And Michigan Peer Review Organization, which is contracted to review charts by the Federal Government of HCFA, denied this admission saying she wasn't ill enough to be in the hospital. The main thrust of her being here was the fact that here's a lady in the snow whose family can't get her into the car and paramedics are called. There is suspicion of a fracture which is quite common that an x-ray initially won't show the fracture and subsequently it will be proved it is fractured and that's why she was here.

Plus she felt she was discharged too soon. I am a doctor, and under current rules regarding incentive care you are not allowed to keep people in the hospital. And this is a real problem. I think a few years earlier we would have kept her much longer and that would have been her testimony.

Senator RIEGLE. Well I appreciate your being here and I appreciate your coming forward and telling us that, that's helpful to have on the record. Thank you.

These witnesses will follow in the order I call the names. Mr. Jim Church, is that you? [Mr. Church indicated it was.] Mr. Wolverton, is Mr. Wolverton here? [Mr. Wolverton indicated he was.] OK You will follow next and Peggy Hinchey, is that you? [Ms. Hinchey indicated it was.]

STATEMENT OF JIM CHURCH ON BEHALF OF FLORENCE COLES

Mr. CHURCH. Thank you Senator. I am here speaking on behalf of my late mother-in-law, Florence Coles. She passed away on May 27, 1985, and a result of cancer of the pancreas. She was a patient of Dr. McElmurray's as well, as am I, my wife, my parents, etc.

She first sought Dr. McElmurray's care 5 months and one day prior to her demise. In retrospect, it's very obvious that her condition was terminal even at that time. But obviously we didn't know it at the time. She sought his care, her complaint being an approximately 25 pound involuntary weight loss in the previous 2 months, extreme abdominal pain, extreme nausea, vomiting. He advised her on her visit on December 26th that if she did not improve very shortly he wanted to hear from her. In fact the reverse was true and 3 days later he admitted her to the Sparrow hospital. He was able to control the vomiting, of course dehydration was a serious concern. She was released 3 days later, which happened to be January 1, 1985.

There was no definitive diagnosis at the time of her release but eventually she did have a CAT scan which lead the doctor to believe she didn't in fact have cancer of the pancreas.

Subsequent biopsy of the pancreas—external with the use of needles—was not able to prove that and it was never proved to the point where she could be subjected to chemotherapy or so forth until an exploratory operation approximately 6 weeks before her death at which time other organs were involved and the pronouncement that it was hopeless was made. And she died exactly on schedule.

I tell you that so that you might understand that on December 17th of the same year, nearly a year after the hospitalization she

received correspondence from Michigan Peer Review Organization. I won't read the letter in it's entirety, but it introduces itself as a Federal contractor under Title 11 of the Social Security Act and introduces its responsibility to review the case. And it says that it was determined that the care provided did not meet payment requirements developed by the Medicare program. "The form describes—this is an enclosed form, of course—describes the findings of our review in greater detail. Because you had no prior knowledge of this Medicare will not (underlined) hold you responsible for the hospital bill and you will not be required to reimburse the hospital for this care."

I received thousands of pieces of correspondence over the years trying to interest me in the correspondence but this the first one I ever saw that encouraged somebody to be apathetic and throw it away. And it is part of Michigan Peer Review Organizations apparant divide and conquer scheme to divide the doctor, the hospital and the patient. In effect they are saying that the doctor's judgment in admitting into the hospital was flawed. The hospital is expected to bare the burden by not being paid and only the patient has the right to appeal, a real split up situation.

I discussed this with the doctor. I was extremely angered by it because we knew how sick she was during this particular period. He adivsed me that this is common place that he is constantly harassed by these people over these things and especially that their harrassment as in this case is not timely. I might add that this hospitalization was reviewed by Sparrow hospital's in-house review organization in anticipation of this sort of thing and they found no fault with the admission.

We asked for a reconsideration. There were in fact two denials this hospitalization I referred you to and the needle biopsy of the pancreas were both denied. On reconsideration, which is done by telephone to their Grand Rapids office, Dr. McElmurray was able to prevail on the biopsy and they did reverse themselves. They did not on this one and we sought an appeal. We were granted the opportuity to come before an Administrative Law Judge for the Social Security Administration here in Lansing. I might add that they were very helpful in allowing us to prepare our case because I am obviously anyone in the audience with a similar problem to pursue these themselves.

We were able to win a reversal. It's my understanding that we were the first family to ever win a reversal in the State of Michigan. But unfortunately months later we find that there are apparently no provisions in the administrative procedures for Title 11 to overthrow the decision of a Peer Review Organization and the bill has not been paid to date to the best of my knowledge.

To qualify these remarks I have no problem with a Review Organization or any system that oversees entitlement programs. I don't propose to write doctors blank checks anymore than anyone else in this room. But this has reached the point of harrassment and we have a program now that you are proposing to build onto and I wish you every sucess in that effort. I have been in complete sympathy with the testimony I have heard today regarding the needs and the short comings of the program. But the foundation of this program is the providers, the doctors and the hospitals, the people

who deliver the government's intent to the patients themselves. And the foundation is in serious need of having its cracks repaired.

The largest political rally ever witnessed here in the State Capital on the Capital grounds happended a year or two ago when doctors came protesting the malpractice crisis. We have seen doctors who have refused to deal with a certain portion of their practice on the basis that they felt they were being harrassed out of it by the cost of malpractice insurance. And I can see on the horizon that doctors will abandon the elderly if they feel they are being harrassed in repayment. It's one thing to set an arbitrary fee schedule—I haven't heard any doctor seriously complain about that. But it's quite another for the government to welch on its obligation and to do so especially in an untimely manner.

So I might add that the Michigan legislature adopted House Concurrent Resolution 33 which addressed this issue very much and your staff has a copy of it. If you would consider it appropriate, I would appreciate it if that resolution was part of the record today.

Senator RIEGLE. It will be.

Mr. CHURCH. Thank you. So in closing it would appear that you and I are somewhere less than 20 years away from being Medicare recipients ourselves and I would certainly like to have a delivery system there to give it to me and not get a birthday card on my 61st birthday asking me to seek my care elsewhere. Thank you.

Mr. RIEGLE. I appreciate this and I want to make sure too that we follow up on your case and see if we can be helpful in some way.

Mr. CHURCH. I have no problem with any government entity or elected official conducting their business in a way that doesn't please me personally. I've had that all my life and I am sure you have to. But when there appears to be no check and balance system here I have a big problem with that. Secretary Bowen has a tiger by the tail and he apparently had better nail it down somehow. Thank you.

Senator RIEGLE. Thank you. Mr. Wolverton.

STATEMENT OF JIM WOLVERTON, MEMBER, MICHIGAN SENIOR ADVOCATES COUNCIL, BAY CITY, MI

Mr. WOLVERTON. Thank you Senator Riegle for allowing me the time to present this testimony. My name is Jim Wolverton. I am a member of Michigan Senior Advocates Council, an advisory council of region seven Area on Aging Based in Bay City, Michigan.

I would like also to address my remarks to the many people that I have worked with in the this elderly involvement that have shown numerous cases of needs—Alzheimers patients—my mother spent 4 years in a nursing home before her demise, my mother-in-law who recently died from cancer in a nursing home. So I have had a little experience with some of these hardships and I have not attempted to list here all the answers of how to address this particular problem because I believe that's what the people have elected you for. But I do want to make some comments to that fact.

I concur that some form of catastrophic illness health care coverage is absolutely needed. People are living longer and having greater likelihood of having multiple chronic health conditions that may

complicate a hospital stay. As health technology continues to advance there is a possibility of people needing longer stays in coronary care or intensive care. As the days continue, families start to count down their life time days and the added worry of looming cost can interfere with their recovery.

A number of different financing methods have been outlined in the various proposals. Congressman Pepper's proposal would offer the most significant coverage while raising taxes to generate revenue. The House and Senate versions suggest that those Medicare beneficiaries who have more income will pay more for the coverage. The Administration's proposal will not raise taxes and offers only a premium increase but also provides the least coverage.

The introduction of a two-tiered approach to financing this benefit is inconsistent with the long time financing structure of programs funded under the Social Security Act. There is a potential for cost increases in future years to be borne solely by the beneficiaries. This in effect would redistribute catastrophic health care costs to the entire group of Medicare beneficiaries.

While safe guarded from losing all their assets from a long hospital stay, these individuals still have no financial protection from financial insecurity due to a long nursing home stay. In fact their savings potential may be depleted by the premium increase. The House and Senate bills define catastrophic care in the context of acute hospital care. For seniors, prohibitive prescription drugs bills are a catastrophe when they can no longer afford food or heat. Nursing home costs are a catastrophe when a spouse at home becomes overimpoverished and can no longer pay for home heating, food, and insurance due to the family resources being used for nursing home care.

The elderly person caring for an Alzheimers patient at home will get little if any help from day to day custodial care while he or she bares the entire cost of the physical care and the emotional cost of isolationism. In most cases when Alzheimers patients go into the nursing home the family resources are further depleted because the care is usually classified as custodial and is not covered by Medicare.

I think catastrophic illness is not limited to long acute care hospital stays. It encompasses all the human conditions that in effect bankrupt people who have worked hard and saved diligently throughout their life time. Examples include costly prescription drugs, custodial long term care either at home or in a nursing home and excessive physician bills.

The time has come for this country to pass legislation that will effectively address the financial and emotional cost of catastrophic care to the elderly. Our Canadians neighbors have a less costly system in relation to their economy that provides comprehensive care to all their citizens including the elderly. It is difficult to understand why a country as great as ours refuses to make the same commitment to its elderly citizens.

Senate bill 1127, while it is a start, is inadequate to address the real problem of catastrophic health care costs. I believe that House of Representatives bill 65 is a comprehensive bill which should be the model for Senate action.

We recognize the cost, but we also recognize that the President and Congress have been able to find funds for a huge defense budget, foreign aid and star wars research. It is a question of priorities and our priority should start at home helping our elderly citizens who help build this great Nation and paid taxes all their life. I think it is time that we recognized that commitment and this country did something about it.

And I want to take this opportunity to thank you Senator Riegle for holding this hearing and affording us the opportunity to comment on this important legislation. We have confidence in your leadership and ability to convey these concerns to your colleagues in the Senate, take appropriate action to meet the needs of our deserving elderly. I thank you.

Senator RIEGLE. Thank you very much. That's a very helpful statement. Peggy, before we call on you I am going to go through the list so we know who's still here waiting to speak. I am going to have you raise your hand if you are here. Thelma Medrea, that's you. Kenneth Baur, Kenneth is here. Ruth Swain. Marie Sterner, yes. Sue Haviland, yes. Jackie Erdman, yes. Sally Clery, yes. Kathy Peterson, yes. Arlo Corwin, yes. Charles O'Brien, Charles O'Brien. Gertrude Tomlinson. Roger Cooly. E.J. Sopcak—how do you pronounce it? Sopcak. Gloria Thomas, yes. Lamar King and Louise, are they still here? Al Barnes. Dave Ellis. Reverend Bedy, is that you? Yes. Carol Jones, OK Lou Anselma, very good. Now we are going to go in that order after Peggy finishes. We will go right down the list. Peggy

Ms. HINCHEY. Thank you Senator Riegle. This is turned on?

Senator RIEGLE. Yes.

STATEMENT OF PEGGY HINCHEY, DIRECTOR, SENIOR CITIZENS GUILD, ANN ARBOR, MI

Ms. HINCHEY. I am not going to go into detail of some of the things I did wish to discuss with you because we have heard much today to document how serious this whole catastrophic illness is. And it is a catastrophe when people are losing their homes and dying mortgaged. I am Peggy Hinchey, the director of the senior citizens guild of Ann Arbor. But we are a United Way agency so I counsel and set up programs for all seniors of Washtenaw county. Last year we served 36 thousand. So I might tell that I have very sad cases that I can document for you when you need them.

My concern that I wanted to speak to you and to the people about today is that after it came out in the newspaper about the President and the Secretary making their observations and recommendations for catastrophic illness care, then all the bills began to be written by the legislators. We have one now, the Stark-Gradison bill. I have read this, and read it, and Senator, it does not cover the need. It's just as the people have mentioned to you today, documented—it is not covering long term care in nursing homes. They stress long term care in a hospital.

Unless something can be done about the present DRG law I can't see where that is going to mean too much. I will have to document the last case I was called about. A lady had a gall bladder surgery. She was in intensive care for 2 days while they decided what to do.

They removed the gall bladder. The fifth day, she still had had no—anything but liquids and she still was running an I.V. and her surgeon and her other doctor walked in and said you are to be dismissed. The fifth day. She still was running an I.V. The nurse had to pull the I.V. They had to call the family and tell them to bring some clothes—they were sending her home.

I have other cases that are as ridiculous and I have some that have caused death, we are quite sure. So until something can be done about the DRG I think it's ridiculous, when statistics show that there are only 8 percent of our seniors of this Nation that had long term care last year. So until something can be done about that. The other thing is this we know that it comes out a bit in the news occasionally about a bill that is being discussed or passed by the Ways and Means Committee. In fact I can't find anyone who knew that the Stark-Gradison bill had been passed by the Health—Ways and Means Committee.

Senator RIEGLE. The Ways and Means Committee.

Mr. HINCHEY. The Ways and Means Committee, thank you. I have covered several counties Pontiac, Monroe and all. I have called people in senior work out in Iowa, out in Nebraska. Oh, are they doing something about it? This is the answer.

So I commend you today and I think everyone should appreciate all the time that you have taken of trying to learn about this and the only thing I can say to the people—that they must notify you in some way. Because you can work you heart out for us but unless we tell you the things that we have found that are wrong, that are not giving the kind of care that you have shown them you want them to have, you can't do anything about it. You have to have this message from the people because we want you to represent us and we feel that you are. But we do have to cooperate.

And so this is why I am telling you what I am going to do in my county and they're coming from other counties. We have engaged a large building that will hold from 5 to 6 hundred people. We are going to notify the people in the other counties by the news media and radio. We are having a panel of people who are knowledgeable of these things that can explain to these seniors what this bill says.

You know and I know that it is necessary to have a book, a page. But how many of our seniors know, or your ordinary person know what is in that bill or what they're going to receive. So how can they react as to how they feel about it? So we are going all out through the guild, on education program to tell the people what this implies.

I am concerned about this sliding scale tax or whatever you want to call it—it is a tax. They're going to pay it through the Internal Revenue at the end of the year, on a sliding scale as it is so written now. But it also states that it can be raised. So I think that all of these things should be explained to the people so that when they voice their opinion and you are to represent them properly that is the way it should be done. And that's what we are endeavoring to do.

So all I can say is, as one man said, regardless of the final outcome Medicare beneficiaries need to understand what is being discussed and not be mislead by benefits which sound too good to be true. I thank you.

Senator RIEGLE. Thank you very much. Thelma we are ready for you. You will be followed by Kenneth Baur, by Ruth Swain. Why don't you come on down and take a seat then you will be ready to go. Thelma why don't you start.

STATEMENT OF THELMA MEDREA, MEMBER, GREATER ANN ARBOR CHAPTER, ALZHEIMER'S DISEASE AND RELATED DISORDERS ASSOCIATION

Ms. MEDREA. My name is Thelma Medrea, 4400 Calvery Blvd. in Okemos and I am a member of the greater Ann Arbor chapter of the Alzheimer's Disease and Related Disorders Association, which serves nine Michigan counties including this tri-county area of Ingham, Eaton and Clinton. I am also an active member of the Lansing family support group. Most importantly, I am an active care giver in my home for my mother who is a victim of multi infarc dementia, one of the progressive incurable related disorders.

Mother came to live with us 13 years ago from Canada when she was no longer able to live independently. Now, however, I am faced with the possibility of having to return mother to Canada where nursing home care is already covered under a national health insurance plan.

The development of affordable community based home care supportive services appears to be a most useful and cost effective means of answering the concerns and needs of families who do not relish either early institutionalization, improvishment, or government dependence. Services such as adult day care, home health aid, nursing and companion services, appropriate case management and referral, training and providing personal care in dealing with difficult behaviors, respite care and alternative housing options such as adult foster care would all be invaluable.

I am very encouraged by the recommendations of the recently adjourned Michigan task force an Alzheimer's disease and related conditions. This group has recommended several long term care services and financing initiatives including support for the reform of the Medicare program by combining Parts A and B and the development of a Part C covering long term care facility and home based care. I would like to send you a copy of this task force report when it's formally presented to the Michigan Cabinet on Human Services council next week, July 7th. I am also very encouraged that just a few days ago joint house and senate conference committees in the Michigan legislature have recommended funding within the Department of Mental Health for the development of community based services for Alzheimer's care such as adult day care, respite care, and care giver training. Though the amount of this funding under matching grant programs will only begin addressing our needs on a modest scale, this funding if passed by full legislature this morning or tomorrow, shows a good faith effort on our State's part to act in a partnership with the Federal Government to study the effectiveness of various long term care alternatives.

Your assistance is vitally needed in encouraging this partnership with the Federal Government's current pilot project funding effort funding under the Medicare program. Specifically I am speaking of $41.2 million which is now availably for Medicare for the develop-

ment of adult day care, respite care, case management and other home and community based care and support services. Your active support in our effort to have Michigan picked as one of the 13 pilot project sites would be greatly and sincerely appreciated.

Your supprt would also be appreciated in efforts to implement changes in the Medicare and Medicaid programs at the Federal level. As recommended by our State's task force we desperately need Medicare coverage for facilty and home based long term custodial care.

In addition a case mix reimbursement system under the Medicaid program would assure the continuing availability of appropriate nursing home services when and if they are finally needed.

At present, the reimbursement system does not recongize the true cost of providing care for the so called heavy burden patient. Facilities are most often unable to provide or retain adequately trained direct care staffing or to enhance environments to assure the least restrictive types of care which are appropriate

Even as we strengthen the support for the majority of victims that are being cared for at home, we must recognize that the small percentage who are institutionalized still comprise over half of our nursing home populations.

Before closing my comments I would like to once again ask you to support our State participation in the $40 million Medicare demonstartion projects as well as the $1.2 million Medicare respite care model development project also now being funded. Such a partnership with our efforts would results in significant benefits to current and future care giving families in Michigan.

For your review I would like to present you with a copy of a recently published report entitled financing care for patients with Alzheimer's disease and related disorders, a briefing by the Subcommittee on Human Services of the Select Committee on Aging, House of Representatives, November 9th, 1986. I would also like to refer your attention once again to the document entitled "Losing a Million Minds: Confronting the Tragedy of Alzheimer's Disease and other Dementias," the Congressional Office of Technology Assessment, April of 1987. This report was prepared at the request of several congressional committees including the Committee on Finance on which you serve.

I want to personally thank you for your support in the development of the this very comprehensive discussion on Alzheimer's disease and related disorders including issues related to the financing of long term care. Thank you for being here today and thank you for allowing me this opportunity to speak. My written testimony as well as other information is enclosed in this folder.

Senator RIEGLE. Thank you very much and I appreciate the care and the time you've taken to prepare that.

[The prepared statement of Ms. Medrea follows:]

LONG TERM CARE:

Addressing the Needs of
Michigan's Alzheimer's Disease
and Related Disorders Victims

Presented to The Honorable Senator Donald W. Riegle, Jr. in Lansing, Michigan

Monday, June 29, 1987

My name is Thelma Medrea (4400 Calgary Boulevard, Okemos, MI). I am a member of the Greater Ann Arbor Chapter of the Alzheimer's Disease and Related Disorders Association which serves nine Michigan counties including this tri-county area of Ingham, Eaton and Clinton. I am also an active member of Lansing's family support groups. Most importantly, I am an active caregiver in my home for my mother who is a victim of multi-infarct dementia, one of the progressive and incurable "related disorders."

Mother came to live with us thirteen years ago from Canada when she was no longer able to live independently. Before that time, she had been a very capable person, a nurse and respected church leader actively involved in community affairs. I've worked through the initial fear, sorrow and stress of the circumstances in our lives, but only because of a very strong family network. Now, however, I am faced with the possibility of having to return Mother to Canada where nursing home care is already covered under a national health insurance plan.

I would like to briefly describe the nature of Alzheimer's disease and the related disorders, keeping in mind that each victim is affected in their own unique way. Initially, the person suffering from dementia has difficulty remembering things to an increasing extent. The abilities to understand, reason and use good judgement are increasingly impaired. Sometimes the onset is gradual, sometimes sudden. Personality changes often appear and victims may become demanding or apathetic, very restless, irritable and easily upset for no apparent reason. In fact, little things may upset the person all out of proportion and hostility or combativeness may suddenly occur. As dementia progresses, it becomes more evident that brain cell damage adversely affects many motor skills such as coordination, walking, speaking and the ability to write. Some people have hallucinations, become paranoid and extremely agitated. Constant wandering and wakefulness around-the-clock become common problems. In the final stages, victims become totally incontinent and unable to feed, bathe, clothe or otherwise care for themselves. They are eventually confined to bed and require constant and total personal care. The course of dementia generally lasts for years; not unusually, for ten, fifteen or twenty years.

Though the onset of forms of dementia can occur as early as the mid-30's or early 40's (as with Huntington's disease) or the early or mid-50's (as with Alzheimer's), most caregivers are older spouses. The demands of providing 24-hour care and supervision often takes its toll in short order on those who may be over the age of 65 or 75 or 85. Private duty home health aide or nursing service without the support of Medicare, Medicaid or private insurance is an alternative not open to most except for a very short period of time. Thus, nursing home care heavily dependent upon Medicaid support has been the most used care alternative.

The development of affordable community-based home care supportive services appears to be a most useful and cost-effective means of answering the concerns and needs of families who do not relish either early institutionalization, impoverishment or government dependence. Services such as adult day care; home health aide, nursing and companion services; appropriate case management and referral; training in providing personal care and in dealing with "difficult behaviours"; respite care; and alternative housing options (such as adult foster care) would all be invaluable.

I'm very encouraged by the recommendations of the recently adjourned Michigan Task Force on Alzheimer's Disease and Related Conditions. This group has recommended several long-term care services and financing initiatives including support for the reform of the Medicare program by combining Parts A and B and the development of a Part C covering long-term facility and home-based care. I would like to send you a copy of this Task Force's report when it is formally presented to Michigan's Cabinet on Human Services Council next week (on July 7th).

I'm also very encouraged that just a few days ago joint House and Senate conference committees in the Michigan Legislature have recommended funding within the Department of Mental Health for the development of community-based services such as adult day care, respite care and caregiver training. Though the amount of this funding under matching grant programs will only begin addressing our needs on a modest scale, this funding, if passed by the full Legislature this morning or tomorrow, shows a good faith effort on our State's part to act in a partnership with the Federal government to study the effectiveness of various long-term care alternatives.

Your assistance is vitally needed in encouraging this partnership with the Federal government's current pilot project funding effort under the Medicare program. Specifically, I'm speaking of the $41.2 million which is now available from Medicare for the development of adult day care, respite care, case management and other home and community-based care and support services. Your active support in our effort to have Michigan picked as one of the thirteen pilot project sites would be greatly and sincerely appreciated.

Your support would also be appreciated in efforts to implement changes in the Medicare and Medicaid programs at the Federal level. As recommended by our State's Task Force, we desperately need Medicare coverage for facility and home-based long-term custodial care. In addition, a case-mix reimbursement system under the Medicaid program would assure the continuing availability of appropriate nursing home services when and if they are finally needed. At present, the reimbursement system does not recognize the true cost of providing care for the so-called "heavy burden" patients. Facilities are most often unable to provide or retain adequately trained direct care staffing or to enhance environments to assure the least restrictive types of care which are appropriate. Even as we strengthen the support for the majority of victims that are being care for at home, we must recognize that the small percentage who are institutionalized still comprise over half of our nursing homes' populations.

Before closing my comments, I'd like to once again ask you to support our State participation in the $40 million Medicare "demonstration" projects as well as the $1.2 million Medicare respite care "model" development project also now being funded. Such a partnership with our efforts would result in significant benefits to current and future caregiving families in Michigan.

For your review, I would like to present you with a copy of a recently published report entitled "Financing Care for Patients with Alzheimer's Disease and Related Disorders - A Briefing by the Subcommittee on Human Services of the Select Committee on Aging, House of Representatives" (November 9, 1986). I would also like to refer your attention once again to the document entitled "Losing a Million Minds - Confronting the Tragedy of Alzheimer's Disease and Other Dementias" (Congressional Office of Technology Assessment, April 1987). This report was prepared at the request of several Congressional committees including the Committee on Finance on which you serve. I want to personally thank you for your support in the development of this very comprehensive discussion on Alzheimer's disease and related disorders including issues relating to the financing of long-term care.

Thank you for being here today and thank you for allowing me this opportunity of speaking with you.

STATEMENT OF HON. KENNETH BAUR, EATON COUNTY, MI

Commissioner BAUR. My name is Kenneth Baur. I am from Charlotte, Michigan, and I am self-employed and a member of the Eaton County Board of Commissioners.

I guess the comments I would like to make are relative to my own case, a catastrophic February. I was more fortunate than those who spoke before me because I recovered. But I would want to relate the cost factor here and then give some comments.

I went in the hospital in February of this year with a heart attack, spending 11 days there and at that time had a cathaterization, learning that I had a blockage and thereon scheduled open heart surgery which was done on 25th of February, which necessitated another 11 days before I was able to be discharged.

Senator RIEGLE. I must just tell you, you look terrific for having had surgery that recently.

Commissioner BAUR. Thank you. I tried to do what they tell me and exercise and so on and I feel very blessed to be able to be able to percolate.

I just want to relate the cost factor here. In the 22 days that I was in the hospital, the total hospital bill was $23,079.79, all of which was paid by Blue Cross with the exception of $12 which came to me as an indication that was not approved. The doctors' costs ware $7900 and I am told that there is a balance of some $2800 that Blue Cross has not approved.

Now, I have carried Blue Cross for many years, many, many years and have not myself used it before—or the family. I would say that I am approaching or maybe over a $100,000 that I paid into Blue Cross. This last year's premium, which included major medical, was $4185.60. Being self employed, I have to figure out to pay those premiums, and my wife and I have felt that to protect ourselves and not lean on someone else, that this is a necessity. And there've been times when we have had to borrow the money to pay the premium.

Just would like to comment on—after I got home I had chance to go through the stack of mail I was very surprised on some letters that were there from Blue Cross. When I first went in, the letter was dated February 10th which would have been the day after I had checked in, they sent a letter to the doctor and hospital saying they authorized 3 days of hospital care for the situation that is apparent. Then on February 13th—and obvioulsy I didn't have the follow-up but the hospital or doctors must have sent reports back—they authorized an additional 5 days.

Then on February 17th, they sent another letter saying they authorized an additional 4 days that they would pay for. Now my point here is—and the reason I relate them in that order is—that I seriously question the capability of somebody in Detroit making a determination of how may days they will authorize to be paid for. Because the first day after I was finally removed from the emergency room and put into intensive care, I was in there for 5 days to start with. So their first letter of 3 days lacked some judgment somewhere along the line and maybe lack of knowledge. And I could just say this relates to some of the other testimony.

And I had a real good friend of mind related to this in Imlay City that told me the story involving his wife with tears in his eyes. She was in a Detroit hospital and they said she's going to have to be dismissed today and he pleaded with the hospital. He said she is in no condition to go home. And finaly he was told rather abruptly you are going to have to. Get some clothes, she's going to have to. He took her from the Detroit hospital and took her to Imlay City and got her in there only because he lived in the vicinity and knew somebody in the local level. And the first thing the doctor said is that what's the matter with your head. She should have never been—what did you take her out of the hospital for in the first place? And this coincides with what was said and really concerns me Senator for other senior citizens as to not being recognized for the apparent need that is there.

Senator RIEGLE. Can I just stop you there, because I think you are really getting the spotlight where we need to have it as to what is going on. Your friend has it happen in Imlay City, so you know about it from there and of course you have had it happen to you so you have seen it. So now you understand it in a way that probably you needn't before. The squeeze is on to try to save money all the way down the line. By squeezing down these costs, whether it is pushing people out of the hospital too soon or not paying people for the bills or shaving down the protection in the coverage, it holds down the costs. And by holding down that part of the cost of the overall size of the Federal budget, that enables more money to be spent for something else, even if you've got a huge deficit.

And I will tell you what my own theory is. Every item in the Federal budget puts pressure on in a sense on every other item. But the fact if we have had a big defensive bill up. And I am not saying we shouldn't have a certain amount of defense build up—I am not here to get into that debate. But that's been given the first priority. And if you give one thing the first priority then you have to take money from everything else to pay for it. That was even part of the reason for the proposed cuts in social security. There was a big fight about that and I happened to be very much involved in the fight to prevent that from happening.

Even though social security was entirely separately funded with its own trust fund, because it was included in what is called the unified budget, if you squeeze down the spending in social security by cutting the benefits you could, then within the overall accounting for the budget, spend money somewhere else where you really wanted to spend the money. So in the case if you have an administration, as we did, that wanted to spend it on defense you could squeeze down the social security and the Medicare spending and you could pump up the spending over here. Even though they are really separate things and should be thought about as separate things, they are connected in that fashion. I think these pressures don't just come out of thin air. They are very real and you can track them back. You have to be a sort of Sherlock Holmes to find out how this system works, why it works this way, where is the pressure coming from, what's the purpose of the pressure, if it's to save money here to spend it over there, what's it being spend on. And finally you can put the whole chain together and you can see that a whole series of events are involved. What you're doing is

helping to bring to light to the fact we got something going on here in terms of this relentless squeezing down of the health care servies and protection. And if you weren't a healthy and robust man, if you had been forced out of the hospital early as your friend's wife was, you might not be here today. And as this women who spoke over here mentioned, they think over in Washtenaw County they can identify people who lives have been lost because they have literally been shoved out the door when they weren't ready to go home because of this artificial pressure that's been created in the name of cost reduction and saving money.

Now that's one man's view. I don't ask you to take my view of it. We are all citizens in a democracy. We have to decide for ourselves and so you have to make a judgment, everybody here does but that's the chain I see at work here. I apologize for the interruption, but you make a point which is important.

Commissioner BAUR. Yes; I can only relate back to the February 10th letter here from Blue Cross where they authorized 3 days. They didn't even let me get out of intensive care until the 5th day to start with. So that very little judgment on the particular individual case was given. That must be rough shod over saying well we will authorize 3 days here and we will pay for that and that is real concerning. It's going to effect, if this continues, it's going to effect our senior citizens such a great deal.

I might tell you that my friend's wife died shortly thereafter and he had quite a talk with the doctor and so on and said that her illness probably would have taken her anyway but he said there is one thing for sure she should have never been taken out of the hospital and drove up here to Imlay City which was quite a few miles.

Senator RIEGLE. Oh sure.

Commissioner BAUR. That was certainly no benefit to her in longevity of her life.

Senator RIEGLE. Well, imagine too, the emotional strain. Imagine how frightened you'd be. Imagine how keyed up you'd get if you are sick and on the verge of dying and you have been in for serious care and you are abruptly bundled up and pushed out the front door. You could imagine the trauma of just that experience. That is enough to kill you.

Commissioner BAUR. It sure is. I just want to cut down or mention a few items here relative to Blue Cross. And I use that example because of their cost. I paid for major medical which I assumed would pretty well cover everything with almost a $4,200 a year payment—that's quite a substantial payment into the kitty. But some of the items as to how they cut—and we are all aware of the premiums that have been raised several times over the last few years.

Now I have talked to a couple of doctors. I trust them, they have no reason to not give me an accurate description but they tell me that it has been many many years, one of them said I think it's even into the early 1970's, since their benefit payments have been raised. And I will just mention a couple to emphasize my point.

The EKGs, which in the condition you are in with a heart attack you have several, the charges are $25. Blue Cross authorizes $16.25. Another one, when it's taken in your room and it takes two people to accomplish this, the cost is $43. Blue Cross authorizes $28.25 of

that payment. Now I don't think that in this day and age the costs are too high to start with.

Senator RIEGLE. No, and what happens is that your basically get chiseled at every stage of the game.

Commissioner BAUR. Well then I paid extra for the major medical which I assumed I had the protection. The doctor for the operation was $4860 which in my opinion is very reasonable. They authorized payment of $3520. The assistant, and there was a little note on the botton of that, was $972 and there was a comment there that they questioned the need for a second doctor when actually there is four doctors involved. But they authorized $704 on that. Now I'd have to say that I think the doctors are both very reasonable and I am very thankful that they were both there and in charge along with the others. I went in at 4 o'clock in the afternoon and came out at 11:30. And my family was able to see me around 1 o'clock in the morning. And I talked to the doctor a couple of days later when I was able to and I said, "How do you stand that?" and he said it's getting rougher. I wear elastic garters because I am concerned about my vains giving out.

Senator RIEGLE. If I may I don't want to stop you before you finish but I am sensitive to the time because we've got a lot of other folks waiting, and you have made such a powerful case. I want to say one other thing to you before you finish so why don't you make one other comment and then I think we have to move to our next witness.

Commissioner BAUR. OK, I could only say Senator that I appreciate the comment that you made. I am in full favor of a strong defense but I compliment you on the comment you made relative to a small portion of that. Certainly the water could be squeezed out of it and I am in full agreement that we are in need of something that would be payment by everyone to establish a kitty so that we assurance that people that are older and people that unable are not going to have the fear of getting done what they need done. I think that's so vital. And than coupled with that kitty being set up in such a manner that it can't be tampered with by other departments so that that can build an equity and be used in the area.

The other comment that I'd like to conclude with and that is I think that there is much more that could be done in the area of what we eat that causes these things. Take for example the fast food situation which are loaded so with fat and salt and other items closely aligned with salt which are detrimental to causing high blood pressure and a cholesterol condition which brings on the heart condition and many other conditions. I'd like to bare out one point that the doctor told me one of his associates that brings this out real clearly.

One of the associates in the cardiology division is from Korea—a well-respected doctor. And he came over here some 5 years ago and was boasting that we eat a lot of sea food and vegetables and we don't have the need for heart surgery in Seoul. After he was here for 3 years he went back to Seoul, Korea to the hospital that he was affiliated with and—this was in October of that year—to his amazement they told him we have performed 19 open heart surgeries this year so far. That concerned him so that he spent some time trying to determine why. He found that 3 years previous, that

many fast food places came in and that some of the Korean people just fell in love with hamburgers and french fries, Big Macs and so forth and he said he went into the health department and discovered that in just 3 years time that fat and salt had caused that much of a condition. The health regulations there are not what they are here.

Senator RIEGLE. Let me stop you. I don't want to do so because I am enjoying the conversation we are having and I appreciate you coming over from Charlotte to testify today. I see we need a new president in this country—we are going to elect one in 16 months. We need one that talks commonsense like you do that will run. Maybe you ought to think about that, see how your heart is doing and give that some thought.

I am going to have to excuse myself because I am going to have to travel across the State to another commitment that I've got to meet. Joan Huffer who is seated beside me is my assistant who works with me on the Budget Committee and with respect to this issue and she will continue this hearing. We are going to listen to everybody who's come to speak. It will all be part of the public record. I will make it a point to read personally the things that are said after I go so I don't want you to feel that if I am not here you haven't spoken to me because in fact you will be. It's very important that we complete the hearing record.

The reason a hearing like this takes a long time is that there is so much to say and we have to build this record or it's hit and run. If we don't do it right you know we don't have enough of the body of the record to really know what the problem is. We had over 250 people to come out today, most of whom wanted to speak, some of whom have had to leave either because of health or other requirements. Those of you who remained are performing a very important service. With that I am going to ask Joan to come over and take the gavel and take the seat and continue the hearing. I thank all of you for coming and we will be back in touch with you as this goes along to keep you apprised of the steps we are taking. Joan.

STATEMENT OF JOAN SWAIN

Ms. SWAIN. There was no support in the 30 year illness of my mother. My father was a veteran who died before the first social security act was ever passed. My mother got rheumatoid arthritis when I was 12 years old, was total disabled by the time I was 16 and myself and my sister—who is 15 months older than I—took care of her for all those years until she died at the age of 50. St. Lawrence hospital in Lansing said she was the worst case they had ever seen.

It would not have been possible to keep a woman in a nursing home for 30 years in a family that was already widowed. But I do want to point out it saved somebody a lot of money that we took care of her personally at home. You understand what I am saying. I loved my mother. It wasn't just mercenary. But it's a fact that if she had to have been taken care of for all that length of years—at the end of 4 years she lost both hands and the use of her feet—it would have amounted, in all fairness, to a considerable sum of money.

Well, I worked part time all the time. But as I worked for the city of Charlotte for more than 30 years, and this situation also happened to the fire chief there and the police chief though their situation was a little bit different because their salaries were not comparable with mine at all. I was not allowed to buy into group insurance. It was not lack of foresight. I simply had no chance whatsoever during my working life to buy any group insurance.

I tried to carry private insurance and I still have a small private insurance. But I learned the hard way how much of it is scam, so much of which doesn't apply to your situation if you are single or this and that. So even trying to do that was not very successful.

The doctor told me to apply for Medicaid. I was denied for the simple reason—not because of income though I have not made as much as $6000 in 1 year since 1951—but $3 or $4 thousand in savings that I was supposed to spend down. I said "no way" for this reason: I have not yet gotten my Social Security. I don't even have that. I will get it in September and it will be very small. And I said what will I have to even pay the deductible for Medicare if I take the only thing, the only foundation, the only financial basis I've had in a life time of working.

If I could do one thing to make and reform this spend down, if my voice can be heard I feel as long as the great need for the catastrophic care. I feel I want to hit a couple other areas. I feel that Medicaid should take into account people that are working and are trying to work because I could only work evenings my salary was naturally very small, remains small. My total end of Social Security will be very small but the fact still remains that I was working and I was working all the time and there ought to be something were it distinguishes between people that are trying and people that don't try. I don't mean that you get inhumane or throw them in a snow bank there is a difference between working and not working and this essentially is what the situation is. I have 3 years to go before I even apply for Medicare. I balked at—I am not saying—it's an unwise thing to say you will never do something because that might end up with what you are doing. But I think it is understandable why I refused to spend down my savings. And I thank you.

Ms. HUFFER. Thank you for testifying. I think Senator Riegle would agree with you. He is also looking at this issue of what to do when people don't have access to health insurance before they qualify for Medicare. It's a very serious problem as well. Our next witness is Marie Sterner.

STATEMENT OF MARIE STERNER

Mrs. STERNER. Well, my statements will be brief and I appreciate the opportunity. My husband has Parkinson's disease, arthritis and has had two strokes. His medication—three that he desperately needs to take—costs us $111 a month and there's no insurance to take care of that. And those are the three, and then he has other problems along the way that takes other prescriptions besides the three. And if we could get a little bit of help, it would help a lot.

Also last October I had eye surgery for a cataract. The doctor gave me the anesthetic—I had a local anesthetic—but he had an

anesthetist on a stand by in case I needed more anesthetic which I didn't. The anesthetist charged $350, was there about an hour and a half, I had to come up with $154 because Medicare would not pay it and they didn't participate in Medicare. They required the full $350 and I think that some of those things should be looked into and I thank you.

Ms. HUFFER. Thank you. You have brought up some important gaps in the Medicare program that we are trying to deal with. Is Sue Haviland still here?

STATEMENT OF SUE HAVILAND

Ms. HAVILAND. Good afternoon. I appreciate the opportunity to present some testimony even though everybody is kind of worn down by this time. Since several others have already made some of the remarks that are included in my testimony I'll try to only hit the hight points of this.

Basically, my focus is on the rationale and the need for inclusion of respite care program in any effective long term care policy.

I am currently with the St. Lawrence Geriatrics Assessment Center at St. Lawrence Hospital and also I'm here representing the Lansing area coalition for respite care programs. It is a well established fact that families, that is, spouses and adult children provide approximately 80 percent of in-home health care to their older family members. For every person living in a nursing home, there are two people with similar impairments who are still being maintained in the community by their family.

A lot of research has shown that the support provided by family care givers is a key variable in determining whether or not that person can be maintained in the community as opposed to having to be institutionalized. Past studies have shown that a major precipitator of placement in long term facilities is the exhaustion of family resources. And by that is not meant so much financial resources as it is physical and emotional resources.

If social policy is designed to address catastrophic and long term illness in the elderly and if that policy is to be effective it must address the fatigue factor of care givers which so often tips the balance towards institutionalizing older people. It must also be kept in mind that many of the care givers are elderly themselves and also have chronic illnesses so that the care giving role then is especially stressful for them.

Based on our experience in the Geriatric Assessment Center we have found that spouses who are care givers many times require surgery themselves or do have an exacerbation of a chronic illness and sometimes are not hospitalized because they are unable to have respite care, anyone to take care of their family member while they are being treated.

Therefore, a critical step in addressing the needs of care givers is respite care which is defined as a service which provides planned intermittent breaks for care givers from the on going responsibility of caring for their member at home. There are several types of respite care which are included in the written testimony.

Therefore, respite care is viewed as a means of decreasing care givers stress thereby supporting the family system so that a person

can be maintained in their home for a longer period of time. It is also our experience in the Geriatric Assessment Center that care givers who are stressed to the point of being burned out are also at great risk for they have the incidence perhaps of emotional and physical abuse ocurring to their elderly family member.

The concern in the Lansing area regarding the need of respite care indeed has been so great that a coalition has recently been formed to address this issue and right now the Lansing Coalition for respite care includes about 45 individuals and 22 agencies that are looking at the issue of providing accessible respite care services. The VA system right now is about the only system where this service is reimbursable through that coverage. So with the exception of the VA system respite care services still remain an out of pocket expense to the family.

Lastly, again just to reiterate that any social policy that is looking at long term care should include a provision for respite care and respite care can really be viewed as cost effective means of maintaining an older person in their home not only are we looking at cost we are looking at quality of life.

Ms. HUFFER. Yes, for both the senior who would rather stay at home as long as they can but also for the family members that want to take care of their spouses and parents. They need that kind of help to be able to do that well.

Ms. HAVILAND. Right. It's the care giver that really is also a major consumer and a major recipient when we are talking about any social policy related to long term care.

Ms. HUFFER. Thank you, you have raised a very important issue that we haven't heard about today. Jackie Erdman

STATEMENT OF JACKIE ERDMAN, HUNTINGTON'S DISEASE SOCIETY

Mrs. ERDMAN. I am here from the Huntington's disease society and I am here as a representative of the society and also as a representative of my family. Huntington's disease is a genetic illness. It is carried by a dominant gene. It attacks the individual usually at midlife somewhere between 35 and 45 years of age. It may hit as early as 2 years, it may strike as late as the 70's. We are here because many of the concerns that are being raised for senior citizens, we also have. Huntington's disease is a disease that—dementia is certainly one part of the disease. My husband is 36 years old. He is disabled. We are not talking only about assets that we have established being drained so bad. I am going into an impoverished situation. We have two children who are 6 and 8 we are also faced with placing them in that situation. Not only would we be making two individuals dependent on the welfare system, we are placing a whole family in that situation and that's how it is in most cases with Huntington's disease.

We have the same needs. We would like that the situation, the disease, the disability be what the focus is in order for care to be given not that age be the determining factor. It's very posible that we're going to be facing the same situation as the Alzheimer's people were indicating of an early placement in a nursing home or the termination of a marriage within the next 2 to 3 years. I don't

think that either one is a good answer. There has to be something else. We don't want to fall through the cracks.

Michigan has wonderful laws that protect handicapped children, that are working in the right direction. They are starting to do more for senior citizens, give them more attention, moving along the right track. Just because we are in an age bracket that we should be self supporting, that doesn't mean that's always the situation.

This disorder is one that individual insurance companies run from. When we turned in—when bills were sent to the insurance company for the initial diagnosis, we were sent statements saying we do not cover for this diagnosis. I am sorry, we didn't get a choice. I don't see that they should either. Physicial therapy was also part of our policy. It was suggested that speech retaining—because there is a constant fear of choking because of muscle spasms that occur in Huntington's disease—and balance training would also be beneficial. They would not cover the physical therapy because there is not a remission in Huntington's disease. It might improve the qualify of his life but there is not a remission, there is not a cure so we were denied the physical therapy for his care.

I just really feel that in-home healthcare or adult day care services could be such a tremendous asset to families in our situation. I am working, I plan to maintain my family as long as I can and will make the tough decisions as we get there. We want to be self supporting. We want my husband to be at home as long as it is safe for him to to be there and home care can help provide that so that I can stay in the work force and so that a family isn't placed in being in a situation of being dependent on the welfare system.

Ms. HUFFER. This is a very serious problem. There are 37 million people in this country who have no health insurance at all and many others who have inadequate health insurance for problems such as you are talking about including clauses that exempt some kinds of illness. While today we have been focusing on seniors, I think Senator Reigle is not limiting his thinking only to the health problems of seniors. I think he recognizes the problem you are talking about. It is a very serious one.

Ms. HAVILAND. Thank you.

Ms. HUFFER. Thank you. Sally Clery.

STATEMENT OF SALLY CLERY, MASON, MI

Ms. CLERY. I am Sally Clery and I am from Mason, Michigan. I am a hospice volunteer but I am also interested in the effects of long term illness that is not skilled nursing and I am talking home health care. I think the thing that impresses me the most when you work with older people is the tremendous strength they have. And all they are asking is that they have help to help themselves.

Working in hospice, we are working with a diagnosis of 6 months. They are a terminally ill person. When you stop and realize that there are 25 million senior citizens in the United States and one in nine are senior citizens as of the census of 1980, by 19—or the year 2,000, you will have one in five Americans that will be 65 years or older. Out of the 25 million that we have today, we have 2.5 million Alzheimer's patients. We have 1.5 million Parkin-

son's disease. And at least 25 thousand or more with Huntington's disease. I have a feeling we sould rediagnose what we are talking about as far as terminal illness is concerned.

These people need the kind of help that we can give them and keep those people in their homes. That's the only thing they say is I don't want to go into a nursing home. If they can have the kind of help—they are beautiful people. A 79 year old taking care of an 85 years old with Alzheimer's continuous 24 hour around the clock coverage for them. They are incontinent. They need to be turned every 2 hours. You can take Parkinson's disease—they are terminally ill people. And I think I need to redefine this in our health care field. Because we know that hospice is cost effective and if hospice is cost effective we can do the same thing to help our senior citizens that want to stay at home. I thank you.

Ms. HUFFER. Thank you. Kathy Peterson. I want to thank you all for staying around to give your testimony.

STATEMENT OF KATHY PETERSON, MICHIGAN PROTECTION AND ADVOCACY SERVICE

Ms. PETERSON. I want to thank you also for staying around. It's real important for everyone to have opportunity to be heard.

My name is Kathy Peterson. I am an attorney and I work for the Michigan Protection and Advocacy Service which is an agency that's designated by State and Federal law to protect and to promote the legal rights of persons with disabilities. As an attorney with the agency, one of my major projects is to work on increasing—or the prospects of increasing the availability of health insurance coverage to persons with disabilities with chronic health care needs and persons who are labeled mentally ill.

As such, this year in February we convened a coalition which is now called the Coalition for Access to Health Care which is comprised of over 225 individuals representing over 100 agencies some of whom have testified before you today and I will not repeat their testimony. But I just wanted the Senator to be aware of the fact we have mobilized this forum and we are working toward the concerns that all people today have expressed.

One of the first things that we are going to do as a coalition is to sponsor a conference in December of this year which will focus on the issues that effect people in this State who are uninsured, underinsured or otherwise unable to access the health care system. And that will be held in December of this year in Lansing and it will be an opportunity not only for our coalition members and for consumers to learn more about the problems but also an opportunity to expose our policy makers—our legislators and our Governor—to the problems that there are in this State as well as learning more about what our State's responsibility is toward this issue verses and in conjunction with the Federal responsibility towards this issue.

I also want to commend Senator Riegle for asking people's opinion on a national health care system. That's something I think that most people look rather negatively upon but something that I feel in my efforts thus far we must look into.

Lastly, I would just like to highlight the fact that we will be inviting Senate Riegle to attend our conference and to speak on behalf of his proposals in the legislature—in Congress—as well as his future directions with this issue. Thank you very much.

Ms. HUFFER. Thank you, very much. Arlo Crowin.

STATEMENT OF ARLO CORWIN, LANSING, MI

Mr. CORWIN. My name is Arlo Corwin, I live in Lansing and I am a foster grandparent. I do a lot of volunteer work. But we are in need of a program like we are trying to get across. I was at a State convention and I contacted shingles the 30th day of March and if I wasn't in health Central I don't know what I would do.

It was $50 for two days of drugs—or prescriptions I should say—and I couldn't stand that on the income that I have got. So I resorted to veterinary ointment which is doing the work. But when it was so hot 2 weeks ago they flaired up again. I went to the drug store and I got some—I know what I want to say and I can't say it—we use it for poison ivy. I used that and the veterinary ointment and it dried them right up again so I found out I can't sweat. But we do need some kind of help from the Federal Government because we are on such a low income. I get just enough Social Security so's I can't go to social service.

Ms. HUFFER. You are caught in the middle.

Mr. CORWIN. We are just caught in the middle.

Ms. HUFFER. Well, fortunately I think I can say to you that the catastrophic bill that they are looking at now in Congress probably will have some kind of coverage for prescription drugs. What exactly that will look like at this point is hard to say. But you have raised an important issue. Thank you for testifying. Roger Cooly, is he still here? E. J. Sopcak.

STATEMENT OF E. J. SOPCAK

Mr. SOPCAK. I think I am going to give a little different perspective. My background is the reason I am here. I have spent at the least the last 5 years in cancer research. I have talked to probably five thousand to six thousand people who have cancer. I have talked to several hundred doctors and oncologists and probably half a dozen or a dozen who are engaged in cancere research in other institutions.

I would challenge the thought that just because somebody grows old that they are going to have a catastrophic illness, that isn't necessary. I really believe that the reason we have catastrophic illnesses, primarily, is the fact that there is money in it. It happens to be the fact that they are cures for many of the diseases that we sit back and talk about but when you talk to the people inside of the organizations you find out at this particular time that cancer alone when you start talking about delivery of health care—forty cents out of every dollar in health care—is taken from cancer patients. That adds up to—right now its—$450 million a day.

Now if somebody were indiscreet enough to report out a cure for cancer, obviously what would happen, you would have 40% surplus hospitals, 40% surplus doctors and nurses and obviously the entire industrial complex that supports all this. So really, and we are not

even talking about the fact that in cancer research when you get into that phase of it through the NCI, National Cancer Institute—for every individual assigned to cancer research in either a hospital or a university, they have a grant of $75,000 per year per person plus grants that are made to study various and sundry therapies or drugs. So basically if somebody did come up and get on top of the Washington monument tomorrow and say ok there is a cure for cancer, I think he probably would get shot before they ever let him put the material in or the therapy into use. So I think that's basically what our problem is. In fact, there is too much money in the illnesses that we have for anybody to come about to at least annouce a cure for any of them.

Secondarily, we have another system, a condition that exists as a result of legislation. And when Congress reported out or at least established the Food and Drug Administration, being a large country, why of course they established a large bureaucracy.

At the present time, the average cost of getting a drug approved by the Food and Drug Administration runs something in the neighborhood of $75 million worth of research. Now the FDA gets none of this; they simply review the research that has been done. And, secondarily, it takes an average of 7 to 10 years to get a drug approved. Well since I was in cancer research it's interesting to me that today, just for an example, if should come up with a cure for cancer today, by the time 7 to 10 years were up and a drug of that type was approved, we would have legislated the death of about 7 million people that that drug would not be available to under the protocol of the Food and Drug Administration because it's purely not accepted by them at that particular time.

I think basically we talk about the cost of insurance and that type of thing would be advantageous to start to consider not needing the insurance and at least improve the quality of life of people. Because when you provide insurance you are starting to not cure an illness. What you are doing is just getting it from here to there. And getting it from here to there is a sick state where the quality of life is low isn't really the greatest thing that's ever occurred. It's much better to get them from here to there in full health or at least approaching full health. So that's basically where I think much of the effort should be. There has to be an attempt some place to haul in this protocol required by the FDA on terminal illnesses such as Alzheimer's and even Huntington's. I am not familiar with that but there is no doubt in my mind—let's see I would say probably 75 percent of the so called catastrophic illnesses—there are cures available today for them. I think we must do something to get those materials through to the general public.

Ms. HUFFER. Thank you for raising that issue. I appreciate your perspective. Gloria Thomas.

STATEMENT OF GLORIA THOMAS, MEDICAL SOCIAL WORKER, ST. LAWRENCE HOSPITAL

Ms. THOMAS. Thank you. My name is Gloria Thomas. I am a medical social worker at St. Lawrence Hospital. Problems of catastrophic and long term illnesses especially effects low income

people, the elderly, and those in the middle years where age alone eliminates them from already scarce home care services.

As a medical social worker I have first hand experience dealing with these problems. For example a 70-year-old hospitalized widow suffering from congestive heart failure would like to return to her home. She will need help, however, in getting out of bed to use a commode and other necessary tasks. She has no relatives to live with her or to live with and she cannot afford 24 hour aid service at a cost of $100 to $150 a day. She has no alternative but to enter a nursing home.

If the widow has a savings account, she will have to spend it for her nursing home care until she meets eligibility for Medicaid. Medicare will not cover any of her care in the nursing home as she does not require skilled care. This is true with most people in nursing homes. They go from needing skilled care, covered by Medicare, to basic care which they pay for out of private funds until they qualify for Medicaid.

The 70-year-old widow frequently neglected her medications and was in need of dental care and new eyeglasses. Unfortunately, neither Medicare nor her insurance rider covered medications, dental, or optical needs, a common problem for the elderly.

Another common example is that of couple who are both in their 80's. The wife was admitted to the hospital because of a fractured hip and then sent home to be cared by her husband with ongoing physical therapy provided by a health care agency. Medicare would only cover intermittent skilled nursing and physical therapy visits. The couple could not afford any private duty care. Their children attempted to help with both care giving and financial aide but being in their 50's and 60's they had their own medical financial responsibilities. The husband later suffered a stroke and the children now have to consider nursing home placement for both parents.

In looking at these two examples which are representative of the problems faced by many of Michigan's citizens, I question the overall savings generated by DRG's and the now proposed prescreening of nursing home admissions when the high cost and inaccessability of home care services and medication not covered by insurance causes individuals to be at risk at home resulting in numerous hospitalizations—the revolving door—and eventual nursing home placement with both increased Medicare and Medicaid costs. The high cost of in-home care and nursing home care creates a new poor now dependent on the system. Therefore, in developing any Federal legislation, I urge you to consider the following. Number one, insurance coverage to pay for more home care services especially 24 hour care on a short term basis. Number two, insurance coverage to pay for prescription drugs and other basic needs—dental, vision, and hearing. Number three, increased and expanded resources for patients of all ages to maintain them in their home or in the home of relatives such as respite care. Number four, development of short term rehabilitation facilities different and separate from nursing homes. Nursing homes have had problems meeting demands created by DRG's. They can't meet the demands of short term beds, they need more staff, they need staff with the ability to handle specialized treatment such as central lines in young adults

with AIDs. Nursing homes have provided long term nursing care and by attempting to meet the short term demand created by DRG's beds become scarce for long term care. Number five, plans or insurance to enable young adults to plan investments to care for themselves and others they may have to support. And number six, a national health plan. Thank you for your concern and time.

Ms. HUFFER. Thank you very much. Reverend Bedy, is he still here? Lon Anselman.

STATEMENT OF LON ANSELMAN

Ms. ANSELMAN. I am a registered nurse, presently working, I am also an Asian American and I am a senior citizen so I have a right to be here. [Laughter.] I am a registered nurse and I am very concerned about the way the health care system is now in our country here in the United States. And here we have been addressing all these problems but, we are not going to the main root of the system. I mean we are trying to cure the problem but the main source of the problems remains untouched.

I am describing a Lansing State Journal editorial last week, accurately describes this, the way our health system is. We have about six thousand hospitals across the Nation that are non-profit, tax exempt hospitals. But here the State Jornal stated that they are trying to compete with each other in spending hundreds of thousand dollars in advertisement, in other things that relate to business other than health care for the patient and maybe money that could go towards buying new equipment. And I think that the Lansing State Journal is right when they say that the competition among hospitals cannot, never, never bring the cost down. It can only bring the cost up because of duplication of services.

In Lansing we have four hospitals and all of them offer the same, basically the same services within the radius of how many miles, you know, where you can get some kind of service here you drive 10 miles away and the same service is there. And all the four hospitals are spending money for the same service that one can have and still be available to everybody within the county. So that is draining a lot of money that could otherwise be spent for patient care for like I said maybe new equipment.

And I firmly believe that one of the causes for the present acute nursing shortage—the American Nurses Association has predicted 1.5 million nurses that we are going to need in the year 2000 and the AIDS situation is not helping any. They also predicted that before the turn of the century, four out of every five hospital beds will be AIDS patients. So that's going to be very very sad for the health care system, too.

But we have nurses—thousands of nurses—leaving the hospital industry because of the frustraction that we are experiencing like that have been said here all morning. And I have seen it, and I have seen it happen and I don't know, I can't pinpoint who's fault it is you know, but I don't know if given these hospitals free enterprise or business status and let them pay taxes and maybe we can generate enough money to pay for national health coverage for everybody.

You know, I come from a very small country before I became a United States citizen. And I do believe when they say that we're one of the most progressive countries that cannot even afford to pay basic health care, afford basic health care, for every citizen regardless of age, race or income. Becaue in my country, we don't have Blue Cross, we don't have insurance, but nobody is denied health care. You can walk into any hospital, you don't need a Blue Cross card, you don't need a Medicare card. Whether you are sixteen, eighteen, fifty-five or ninety-five, everyone is entitled to health care and you can, like, sue any doctor who will refuse to treat you because yoy don't have the money to pay him right there. And maybe we could see some of these things happening here if we have legislation probably that will go through. I firmly believe in national health care coverage because of the things I have been seeing around. Thank you.

Ms. HUFFER. Thank you.

Ms. ANSELMAN. I would like to help the Senator in his whatever you know, I can contribute, or work for him personally if needs be. But I would like to see something done so that by the year 2000 every single child, adult—everybody—is entitled to the same health care. Thank you.

Ms. HUFFER. Thank you. Those are all the sheets I have. Is there anyone else who would like to make a statement? Thank you all for staying. This hearing is adjourned.

STATEMENT OF LAMAR KING, TRAVERSE CITY, MI

MR. CHAIRMAN. MY NAME IS LAMAR KING OF THAVERSE CITY. I THANK YOU FOR THIS OPPORTUNITY TO STATE MY PERSONAL VIEWS AND EXPERIENCES RELATING TO CATASTROPHIC ILLNESS.

BEFORE PROCEEDING, HOWEVER, I WISH TO REMIND EVERYONE THAT "CATASTROPHIC ILLNESS" APPLIES TO EVERYONE - YOUNG AND OLD ALIKE. THE DIFFERENT DISEASES WE ARE COMBATING, ARE IN MOST CASES "TERMINAL" AND CAUSE SUCH PAIN AND SUFFERING THAT ONLY THE ONES INVOLVED REALLY UNDERSTAND THE HORROR OF SEEING THEIR LOVED ONES SLOWLY SLIP AWAY, IN A DRUG INDUCED STATE OF WHAT WE CALL DIGNIFIED DEATHS, SUCH AS CANCER, OF WHICH I AM FAMILIAR.

I SPENT FOUR WEEKS IN THE "CANCER WING" AT MUNSON MEDICAL CENTER, AND HAD PLENTY OF TIME TO DISCUSS CANCER PROBLEMS WITH OTHERS THAT SAW THE EFFECTS OF CANCER ON THEIR LOVED ONES.

MOST COSTLY TO THE INDIVIDUAL ARE THE DRUGS REQUIRED JUST TO STAY ALIVE, AFTER FIRST SUFFERING WITH CHEMO THERAPY, COBALT TREATMENTS, AND RADIATION. "CHEMO", WHICH IS A POISON INJECTED INTERVENIOUSLY, IS ADMINISTERED EVERY 21 DAYS, FOLLOWED BY PILLS THAT MUST BE TAKEN EVERY DAY. THE PILLS, OF COURSE, ARE BY PRESCRIPTION AND COST ANYWHERE FROM $200 to $350 PER MONTH PLUS THE $150 FOR CHEMO EVERY 21DAYS - WHICH MEANS YOUR COST IS ABOUT $500 A MONTH PLUS, JUST TO KEEP YOU ALIVE. THAT'S THE STANDARD APPROVED TREATMENT FOR MULTIPLE MYLOMA CANCER ACCORDING TO THE AMA. I CHECKED THE DIFFERENT RESEARCH CENTERS AND THEY ALSO PRESCRIBE THE SAME METHOD OF TREATMENT. IF YOU DON'T FOLLOW THIS TREATMENT PROGRAM, THEN YOU ONLY HAVE SIX MONTHS TO LIVE - WITH THE TREATMENT PROGRAM, YOU HAVE ROUGHLY 2 YEARS.

THE DRUGS ARE AS FOLLOWS:

CYTADREN - 1.00 ea. (8 a day) = $240.00 PER MONTH.

DECABRON - 1.25 " " " " = $300.00 " "

NOTVADEX - 1.00 " (2 a day) = $60.00 " "
(BREAST)

MEGACE - 1.00 " " " = $60.00 " "

IN TAKING THE CANCER TREATMENT, MOST ALL CASES REQUIRE AN ANTIBOTIC TO COMBAT BACTERIAL INFECTION, BROUGHT ON BY THE CHEMO AND PILLS TAKEN DAILY. THIS ANTIBOTIC IS TO KEEP THE PATIENT STABLE, AND IS USUALLY "CYTOXAN" AT 1.50 EA. AND UP TO 6 PER DAY - FOR ANOTHER $270.00 PER MONTH.

AS YOU CAN SEE BY THE FEES INVOLVED TO KEEP A PATIENT ALIVE, IT COMPLETELY WIPES OUT THEIR SAVINGS IN NO TIME AND REDUCES A FAMILY TO BELOW THE U.S. POVERTY LEVEL.

IN THE FORGOING STATEMENTS MEDICAL SERVICES AND GOODS NOT COVERED BY MEDICARE CAUSE ANOTHER BURDEN BENEFICIARIES ALSO FACE - SIGNIFICANT OUT-OF-POCKET COSTS FOR THOSE ACUTE MEDICAL SERVICES AND GOODS, WHICH IN THE CASE OF CERTAIN SERVICES, ARE SUBJECT TO MEDICARE'S DURATIONAL LIMITS.

THESE ACUTE CARE SERVICES AND GOODS INCLUDE:

OUTPATIENT PRESCRIPTION DRUGS.

BALANCE BILLING BY PHYSICIANS ON NON-ASSIGNED CLAIMS.

DENTAL SERVICES / PRODUCTS

OPTICAL SERVICES / PRODUCTS

HEARING CARE SERVICES / PRODUCTS

ROUTINE PHYSICAL EXAMS, INFLUENZA SHOTS, PAP SMEARS, ETC.

OUT-OF-POCKET EXPENDITURES FOR THESE NON-COVERED ACUTE CARE SERVICES AND GOODS CAN BE STAGGERING; MORE THAN $7 BILLION FOR OUTPATIENT PRESCRIPTION DRUGS IN 1986; ALMOST $3 BILLION FOR BALANCE BILLING BY PHYSICIANS, MORE THAN $2.3 BILLION FOR DENTAL CARE AND MORE THAN $1.4 BILLION FOR EYE CARE.

WE URGENTLY NEED A PROGRAM AS STATED HEREWITH:

A. LOW INTEREST LOANS SUCH AS "FEDERAL DISASTER LOANS"

B. PROTECTION AGAINST SPOUSAL IMPOVERISHMENT; COMMUNITY SPOUSES SHOULD NOT BE FORCED TO LOSE THEIR ENTIRE LIFE SAVINGS.

C. LOW-INCOME PROTECTION; CASTASTROPHIS COVERAGE FOR LOW-INCOME INDIVIDUALS UP TO THE FEDERAL POVERTY LEVEL.

D. TASK FORCE TO STUDY COST OF DRUGS RELATED TO CANCER AND ALZHEIMERS DISEASE AND OTHERS WHICH CAUSE TERMINALLY ILL PATIENTS TO ACTUALLY GO BROKE, JUST TO SURVIVE A LITTLE LONGER.

E. A PRESCRIPTION DRUG BENEFIT: OLDER PERSONS CITE HIGH COSTS AS THE SECOND MOST IMPORTANT REASON FOR NOT GETTING PRESCRIPTIONS FILLED.

THE ABOVE COULD BE FINANCED BY INCREASING THE MEDICARE PREMIUMS, ALSO INCREASE TAX ON ALCOHOL, TOBACCO AND NIGHT CLUB ENTERTAINMENT, AND ALL SPORTS ACTIVITIES.

IN CLOSING, LET ME STATE THAT IN OUR DEMOCRATIC FORM OF GOVERNMENT, WE ARE BORN INTO TAXATION AT BIRTH, AND WE CONTRIBUTE ALL OUR LIFE TO TAXATION, SO WE SHOULD HAVE THE RIGHT TO DIE IN DIGNITY THRU OUR TAXATION PROGRAMS!

THANK YOU!

STATEMENT OF MRS. H. LOYLE, MANITOU BEACH, MI

I am writing to you because of my deep concern regarding the prohibitive cost of long-term nursing home health care.

As a result of my husband's illness, Alzheimers Disease, we are spending our life savings for his care. I would like to acquaint you with my husband's background. During his working years, he was for 12 years supervisor of electrical engineering at Reo Motor Car, Lansing; and for eight years maintenance supervisor in charge of operations at three plants owned by Gerity Michigan Corp. About 1950, he entered into a partnership with the Dunbar Brothers (Dunbar-Borton, Inc.) as vice president and general manager in charge of approximately 100 men doing commercial work around this area. The company did plumbing, heating, air conditioning, and sheet metal work. Also, he was President of the Mechanical Contractors of America, representing the State of Michigan.

Today, because of Alzheimers, he cannot sign his name or care for himself. After 7-9 years of caring for him at home, it was necessary to place him at Lenavee Medical Care Facility. The care by Aides and Nurses is very good, but at a cost of $2,100, or more, monthly.

We have been married for 33 years and have both worked hard. I quit my job to care for Mr. Borton and now at the age of 63, would probably find it difficult to seek employment.

It is devastating to our family to see a husband and father changing in such a fashion. We have three children ages 30, 28, and 29. My husband also has 2 older children by a previous marriage.

I had hoped to keep him in our home, but when it became apparent that he could no longer be cared for at home, the necessary steps were taken.

At the present time, I don't even know how I will pay necessary heating and other expenses to maintain our home for the next year. I know of no insurance that pays for this type of illness. Medicare does not—it is called basic or custodial care. We have paid hundreds of dollars to Blue Cross/Blue Shield over the years, but unless I would enter a hospital for care, very little is covered. The only compensation we have received from Medicare for my husband since last October is a small amount for doctor visits and the podiatrist. These two things were very minimal compared with the overall costs.

There must be a better way to compensate the elderly for care when they have worked hard all of their lives.

Without faith, I would have given up in despair a long time ago. Please give this matter your very earnest consideration.

NATIONAL FEDERATION OF THE BLIND
1800 JOHNSON STREET
BALTIMORE, MARYLAND 21230
MARC MAURER, President

For more information please contact:
James Gashel
Director of Governmental Affairs
(301) 659-9314

LEGISLATIVE MEMORANDUM

From: Members of the National Federation of the Blind

To: Members of the 100th Congress

Re: The Blind: A Legislative Platform for Freedom--Priorities for the First Session of the 100th Congress

"For what avail the plow or sail,
Or land or life, if freedom fail?"
--Ralph Waldo Emerson

"The history of the world is none other
than the progress of the consciousness
of freedom."
--Friedrich Hegel

"These things shall be--a loftier race
Than e'er the world hath known shall
rise
With flame of freedom in their souls,
And light of knowledge in their eyes."
--John Addington Symonds

Freedom is a desired state of being that all people (blind and sighted alike) share in common. Fifty thousand people (including those who are born blind) become blind in the United States each year.

Blind Americans share a unique struggle for freedom. Most sighted people in our society have had some contact with blindness through friends, family members, co-workers, colleagues, business associates, or other forms of social interaction. But despite these contacts, blindness remains one of the most misunderstood conditions. We are not even accustomed to the idea that the blind would need to struggle for freedom. The more common understanding is that the blind (presumably being in need) are taken care of. So why would they want to be free? Assumptions such as this are part of the great misunderstanding about blindness, and that is why we who are blind must now struggle for our freedom.

More than anything (including the physical limitations of blindness), lack of knowledge and misunderstanding about blindness result in public policies, public programs, and even laws that diminish opportunities for blind people to exercise freedom and their potential to the full. This is why we have formed the National Federation of the Blind (NFB).

NFB is a private sector resource of knowledge, encouragement, and support for the blind and for all people (blind or not) who seek greater freedom and opportunity for the blind. We are proud of our self-help traditions, philosophy, and achievements. The vast majority of our members are blind. We join NFB through local chapters and statewide organizations everywhere in the United States.

We are the voice of the nation's blind--the blind speaking for themselves. Our priorities for the first session of the 100th Congress include three freedoms: (1) the freedom to travel; (2) the freedom to work; and (3) the freedom to learn. (See brief descriptions which follow.) This freedom platform for the blind is nothing less than our declaration of equality and independence in three critical areas of human life.

Decisions which can and will be made during this session of the 100th Congress will significantly affect our achievement of these three freedoms for the blind of America today. Accordingly, the following positions are advanced in order to help focus the issues and provide solutions that will build lives of freedom for the blind both now and in years to come.

(1) **Freedom to travel--** Congress should act to assure fair treatment for the blind in air travel. This request seeks renewed and continued actions by members of Congress (including oversight by appropriate committees of Congress) aimed at freeing blind people from discriminatory practices of many commercial airlines and the commercial aviation industry itself. The "Air Carrier Access Act" (passed last year and signed into law) has not yet been implemented by the Department of Transportation (DOT).

The law (Pub. L. 99-435) prohibits commercial airlines from discriminating against qualified handicapped people. But the airlines' and DOT's regulation writers and enforcement personnel are behaving as though Congress will allow the usual discriminatory procedures to continue without further action to require fair treatment in air travel. It seems that the airlines and federal enforcement authorities have little regard for the law or the will of Congress, and there is no predicting how long the new law will be ignored. While it is ignored, blind people are denied the freedom to fly without having airline personnel whimsically exercise toward them misunderstood, misapplied, and misguided procedures. Most outrageous are the arrests of blind people who take seats assigned to them by the airlines and then are arrested and hauled off to jail for not moving. Yet, DOT enforcement authorities refuse to intervene to protect the personal liberties and safety of blind passengers. The fact sheet entitled "Air Travel for the Blind Means Hostile Skies: Action Needed Now" gives more details and suggests specific

actions that should be taken by all members of the 100th Congress.

(2) **Freedom to work--** Congress should amend the Javits-Wagner-O'Day Act to provide that all jobs in workshops supplying products to the government are made available on a priority basis to blind and severely handicapped persons who qualify. This proposal seeks specific legislative reforms to expand the number and type of employment opportunities that are created for blind and handicapped people through special government procurement arrangements made under the Javits-Wagner-O'Day Act. Under existing law direct labor jobs are promoted for the blind and handicapped. This has resulted in a tokenism approach in most workshops which employ only a few blind people in responsible jobs.

The proposal for amendments to the law will assure more even-handed opportunities for the blind to participate in all workshop jobs and to be given training and other forms of consideration for employment at increasing levels of responsibility and pay. The fact sheet entitled "Federal Buying From Workshops Limits Job Opportunities for the Blind: Reforms are Needed Now" gives more details and background with specific rationale for improving known and documented deficiencies in workshop hiring and employment practices.

(3) **Freedom to learn--** Congress should amend the Social Security Act to give blind beneficiaries of Social Security Disability Insurance and Supplemental Security Income the flexibility they need in choosing acceptable and desirable sources of post-secondary training and employment services. This proposal seeks to give the blind a free choice in selecting, designing, and receiving the assistance normally required to become employed and self-supporting. Under existing law beneficiaries of Social Security programs (and all other blind people seeking training and employment services) are blocked in most cases from obtaining this help through any agency other than a single agency in each state, approved by the federal government. Existing law authorizes Social Security to reimburse the state agencies when a beneficiary achieves employment, but states are reluctant to participate substantially in this "results-oriented" program.

Funding participants (rather than programs) would be a better option. That can be done by letting each beneficiary choose which agency or agencies will be most responsive. The beneficiary (not a government agency) is often in the best position to know which agencies can best meet the need. Under a plan which gives beneficiaries a free choice of agencies and programs, cost-effective reimbursement for training and employment services for the blind could be made to private agencies as well as to state rehabilitation agencies. The outline and advantages of the free choice plan are presented in the fact sheet entitled "Breaking the Monopoly: A Free Choice Plan for Training and Employment of the Blind."

Blind people are asking for your help in securing positive action by Congress and the executive branch in the areas outlined here. To the extent necessary new legislation to achieve these and our other objectives will be introduced in the 100th Congress.

Many priorities confront this session of Congress, but the needs of the nation's blind must not be neglected in the legislative agenda. We of the National Federation of the Blind stand ready to assist our Representatives and Senators to understand our needs and to take meaningful action to address them. This year we are seeking to achieve three priority goals of freedom--freedom to travel, freedom to work, and freedom to learn. In partnership with the National Federation of the Blind, each member of Congress can help secure these three freedoms for the blind. Freedom in all areas of life is our greatest national resource. It was the quest for freedom that burned in the hearts of the founding fathers of our country. It is freedom from tyranny and freedom to achieve that have made our country great. So it is for the sighted--and so it must be for the blind.

For further information contact:
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FACT SHEET

AIR TRAVEL FOR THE BLIND MEANS HOSTILE SKIES: ACTION NEEDED NOW

Our Goal: Freedom to Travel

The Problem: Commercial air travel is essential for most people and no less so for blind people, but many airlines treat blind people as second-class citizens. They require the blind to obey restrictive procedures normally used for very small unaccompanied children or for people unable to think or act for themselves. The procedures vary markedly among the airlines. Federal authorities deny condoning the demeaning restrictions while covertly encouraging the airlines to discriminate and adopting a "hands-off," nonenforcement posture.

Some of the commonly practiced, unjustifiable restrictions are: prohibitions on seating blind people in or near emergency exit rows (not applied by all airlines, and not a federal requirement); other seating restrictions (such as window seats only) placing blind people at or near the end of emergency evacuation lines (applied by a few but not by most airlines); specific instructions for blind people to evacuate after others in an emergency (frequently stated by flight personnel during patronizing pre-flight briefings given especially to the blind, regardless of their flying experience or ability to comprehend the public announcements); required pre-boarding of blind persons so as to separate them from the rest of the passenger load, including people with whom they may be traveling; seatbelt fastening exercises in which blind people are required publicly to prove to the satisfaction of the flight attendant that they can fasten and unfasten a seatbelt; and countless other similarly demeaning procedures applied routinely to the blind without justification.

Aviation industry officials increasingly seek to enforce these restrictions with condescending hostility. There are instances of physical abuse and attack upon blind persons during recent hostile confrontations provoked by airline personnel. In a sharply rising tide of incidents, verbal threats have publicly been made to blind passengers to embarrass and bully them into compliance with unreasonable demands. Blind people who take seat assignments given them by the airlines are almost routinely arrested for doing so. Yet, federal enforcement authorities at the Department of Transportation (DOT) have declined to intervene to protect the personal liberties and safety of blind passengers by refusing seriously to consider specific complaints.

Status of Federal Law and Regulations: The "Air Carrier Access Act" (Pub. L. 99-435) prohibits discrimination by airlines against qualified handicapped persons. Even without that law, Section 404 of the Federal Aviation Act of 1958 and regulations at 14 CFR Part 382 give DOT enforcement authority to combat discriminatory practices of airlines. In one case (DOT vs. Southwest Airlines) these legal

provisions were successfully applied.

No regulations have been issued to implement Pub. L. 99-435. Having effective rules may take some time. Nothing will be done, however, if the process to make the rules never begins. Meanwhile airlines are disregarding the law. DOT has done nothing to urge voluntary compliance by the airlines or to step up enforcement of existing nondiscrimination regulations. This federal "hands off" posture gives airlines a clear message: "It is still all right to discriminate against the blind." As one official of an airline recently said: "Congress doesn't run this airline."

Lax Enforcement: Secretary of Transporation Elizabeth Dole has acknowledged to Congress that DOT can order airlines to stop discriminating against the blind even without issuing specific regulations under Pub. L. 99-435. However, DOT's pattern of inaction and nonenforcement does not match Secretary Dole's affirmative stance. Complaints filed with DOT's enforcement offices are commonly met with ambivalence if not with hostility and are summarily dismissed. The facts (contained in airline statements plainly showing discrimination) are not considered seriously. The only perceivable enforcement policy of DOT is to deny complaints with the sole exception of the extreme circumstances of the Southwest Airlines case.

Actions Needed: Members and committees of the Congress should act now to forestall further delays in rulemaking and enforcement to implement the Air Carrier Access Act and existing DOT regulations. Letters should be sent to Secretary Dole to insist:

(1) that the rule-making procedure to implement Pub. L. 99-435 begin immediately without further delay or indecision;

(2) that Mrs. Dole should use the informal powers of her office to persuade airline officials to cooperate in a voluntary initiative to reverse the pattern of hostile incidents against the blind; and

(3) that she direct DOT personnel to strengthen enforcement of existing regulations as an interim step to carry out the will of Congress and the President in approving Pub. L. 99-435.

Members of responsible committees of Congress (including Authorizing, Appropriations, and Oversight Committees and Subcommittees) should be alert to all possible opportunities to ask Secretary Dole and other DOT officials for progress reports on steps being taken toward achieving the objectives stated here.

In the Federal Register of August 22, 1986, 51 FR 30078, DOT asked for public comment on specific issues of air travel discrimination against the blind. Comments (especially from blind persons) were extensive. They form a sufficient record for DOT to act now on resolving all of the blindness-related airline discrimination problems. The eventual full implementation of Pub. L. 99-435 could be helpful. Meanwhile the gravity of the pattern of discrimination against blind people demands immediate interim action under existing authority consistent with the clearly expressed will of Congress. No rationale (bureaucratic or otherwise) can now be given for failing to pursue such efforts.

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FACT SHEET

FEDERAL BUYING FROM SHELTERED WORKSHOPS LIMITS
JOB OPPORTUNITIES FOR THE BLIND:
REFORMS ARE NEEDED NOW

Our Goal: Freedom to Work

The Problem: Federal agencies are now required to buy certain products from qualifed nonprofit suppliers, called sheltered workshops. This policy is intended to promote employment for blind and severely handicapped people, but the jobs are limited to light industrial, assembly, and packaging work, generally referred to as "direct labor."

With only token exceptions the supervisors and managers in this federal program are not blind or severely handicapped. They have full-time salaried positions with pay and fringe benefits that match industry standards. Meanwhile the blind direct labor employees are often paid only the minimum wage or far below.

Workshop managers tenaciously fight the right of blind workers to organize labor unions. Layoffs for the direct labor employees are commonplace. Months elapse during which many of these blind workers have no work and no unemployment compensation to tide them over. Their non-blind managers and supervisors are full-time and well paid. Even the sighted who work in direct labor receive fair wages in contrast to the much lower pay received by blind employees, who perform similar work and often out-produce the higher paid sighted employees. A typical example is a Connecticut workshop that recently reported average pay for blind workers of less than $2.00 per hour. Sighted employees in the same workshop doing similar tasks were paid over $4.00 an hour.

Reforms Needed: Congress should amend the Javits-Wagner-O'Day (JWOD) Act to insure that all jobs in the sheltered workshop program it supports are made available on a priority basis to qualified blind and severely handicapped persons. Options to be considered should include:

(1) requiring participating workshops to have specific, written goals and timetables for promoting or hiring qualified blind and handicapped persons into all positions beyond direct labor;

(2) special recruiting procedures which each participating workshop must follow in obtaining an adequate pool of qualified blind and handicapped applicants for all positions beyond direct labor;

(3) training, advancement, and career development programs at participating workshops so that blind and handicapped people are given

opportunities to become qualified for responsible positions at all levels;

(4) non-interference requirements to protect organizing and collective bargaining rights of all employees of participating workshops; and

(5) other administrative changes to improve federal leadership and monitoring of employment opportunities and rights of employees and applicants for employment in this program.

Recent Congressional Action Makes Progress Possible Now: Until recently, protecting the rights of workers has not been a driving concern in passing legislation favorable to workshops. Managers of shops promote themselves as benevolent caretakers of the blind, but persistent reports of low pay and dissatisfied workers have made members of Congress cautious in considering new concessions for workshops without worker protection features built in. Last year's amendments to the Fair Labor Standards Act (Pub. L. 99-486) show that Congress is becoming more sensitive to the need for protecting workers' rights even in sheltered workshops. Refusal by the last Congress to give for-profit small business set-aside contracts to non-profit sheltered workshops also shows that workshop bills must promote labor interests in order to pass.

Now it is time for Congress to act affirmatively on a broader but modest reform of the JWOD program. The House is already on record in support of better employment opportunities for the blind in administrative and technical support jobs with the two central management agencies that are designated to operate under the JWOD Act. (See H.R. 5294 and House Report 99-723, making appropriations for the Treasury, Postal Service, and General Government for Fiscal Year 1987, 99th Congress, second session.)

During the previous year the Senate Appropriations Committee also found deficiencies in the JWOD program's employment practices in failing to hire and promote blind and handicapped persons. (See Senate Report 99-133, 99th Congress, first session.)

On a broader scale the House Committee on Government Operations found "tokenism" in the hiring and promotion of blind and handicapped persons into management and supervisory jobs in the JWOD program. (See House Report 98-546, "Improvements Needed in the Admiminstration of the Javits-Wagner-O'Day Act," 98th Congress, first session.)

These documents show that responsible committees of the Congress are well aware of the need to reform employment opportunities for blind and severely handicapped persons in the JWOD program. Further study of these issues will not materially change the legislative result, but it will certainly prolong the delay in achieving a solution beneficial to the blind and severely handicapped workers under the Act. The JWOD Act has existed almost unchanged in its basic employment approach and philosophy since 1938. Now it is time to update and improve the law by insuring that all blind and handicapped workers have a fair chance to be hired for all jobs for which they can qualify. That is the modern-day standard which Congress has set in equal employment opportunity legislation. Employing the blind and handicapped at all levels throughout this program will not occur unless the underlying law is changed.

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FACT SHEET

BREAKING THE MONOPOLY: A FREE CHOICE PLAN FOR TRAINING AND EMPLOYMENT OF THE BLIND

Our Goal: Freedom to Learn

Background: In 1920 Congress created the Vocational Rehabilitation Program for the purpose of providing job skills and employment to handicapped people who could work despite their impairments. The term "vocational" was deliberately used to identify the employment-centered nature of the program's goal.

In more recent times, however, the term "vocational" has been dropped from the name of the law altogether. With that change and other substantive amendments to the original, basic legislation the goal of employment for the handicapped is becoming ever more obscured.

The modern-day rehabilitation act (known as the Rehabilitation Act of 1973, as amended) authorizes and supports a constellation of medical, social, recreational, vocational, educational, and research oriented programs and other efforts that are intended to improve the living conditions and life styles of all disabled persons in America. Employment is now one of many objectives of the law, and certainly no longer the principal one.

Yet, lack of good training and employment opportunities remain the uppermost priority need to be fulfilled for more than 70% of all blind people from the time of high school graduation to retirement age. Recreation, social services, and even medical care needs will almost all be met for the vast majority of these blind people if they get suitable jobs with pay and responsibilities commensurate with their individual abilities.

Existing Law: Current programs (supported with almost 1.3 billion dollars in federal financial assistance) are operated largely on a single state agency concept. The blind person in need of training and employment assistance must seek help from a specific state government agency designated by law to receive the federal government's blessing and funds to provide rehabilitation services.

The state agencies thus control the money (and in many respects the lives) of those blind people who are trying to become self-supporting and free from government assistance. Options for choosing the agencies from which to seek training and employment assistance are realistically nonexistent for most blind people. Lack of a free choice for each blind person to obtain needed services from a public or private agency, selected by the individual (not by the government), is a major deterrent to effective, responsive training and employment assistance. Blind people who need help to get jobs are interested in results, not in programs.

Description of the Free Choice Plan: The free choice plan for training and employment services can operate in tandem with the present federally assisted state agency structure already in place under the Rehabilitation Act of 1973. Under a 1981 change in the Social Security Act, funds from the Social Security Disability Insurance (SSDI) trust fund and appropriations for Supplemental Security Income (SSI) are paid to the state rehabilitation agencies whenever an SSDI or SSI recipient achieves successful work as a result of a rehabilitation program. But since results (successful work) are essential under the law for a state agency to obtain reimbursement from the SSDI or SSI funds, most of the state agencies participate only to a small extent in the rehabilitation program authorizing the distribution of Social Security funds when successful work is achieved.

A natural alternative to the present Social Security funding arrangement would be to allow recipients of SSDI or SSI benefits to designate for themselves individually selected sponsoring agencies, public or private. These individually chosen sponsoring agencies could provide services directly or help to obtain services from other programs. This approach (funding the participants and letting them choose their programs) would give each person a wider selection of relevant training and employment services. Since most blind people who are not employed receive either SSDI or SSI cash benefits, they would be immediately eligible to obtain the training and job related assistance they need through the free choice plan. They could continue with a rehabilitation program under the existing state agency structure; or, with the help of a sponsoring agency of their choosing, they could obtain alternative training and employment services through any other program they select. In either case SSDI or SSI funds would eventually pay the bill as is now done through state rehabilitation agencies only. The cost to the Social Security funds would not be increased.

Advantages of the Free Choice Plan: The free choice plan would be a natural adjunct to the existing state rehabilitation agency structure. It would leave the existing programs intact with all of their present financial support now provided under the Rehabilitation Act. The difference would be greater selection of relevant services not limited to those available through assistance by a single agency in each state. State boundaries (and limits on out-of-state expenditures) would not prevent finding the best program for each individual. Under the free choice plan a source of funding (not tied to any state or any agency) would be available for anyone who wanted to exercise a free choice.

To the extent that such a program would stimulate competition among agencies to make their philosophies and programs attractive to potential participants, the free choice plan would create a healthy new environment of services full of new opportunities and growth. In addition, Social Security funds paid to achieve training and employment goals would reduce demands for continuing cash outlays from the SSDI and SSI programs. This is a cost-effective approach that Congress should now enact.

CATASTROPHIC AND LONG-TERM HEALTH CARE

FRIDAY, AUGUST 28, 1987

U.S. SENATE,
COMMITTEE ON THE BUDGET,
Marquette, MI.

The committee met, pursuant to notice, at 1 p.m., at the Don H. Bottum University Center, 540 West Kaye Street, Marquette, MI. Honorable Donald W. Riegle, Jr. presiding.

Present: Senator Riegle.

Staff present: Joan Huffer, legislative assistant.

Senator RIEGLE. Welcome to everybody in attendance today. This is a tremendous turnout on this question of obtaining adequate health care. The problem of adequacy and availability of health insurance is a problem for people in our country of all ages. Today, we will look at these problems, and give special emphasis on senior citizens but we will also talk with some younger people who are for one reason or another unable to get health insurance.

This is an official hearing of the Senate Budget Committee, and will be the sixth meeting of this kind that I have been conducting across the State of Michigan in order to understand fully what's happening in this health care area. Many individuals and families are facing high costs due to illnesses that strike without any warning or accidents that take place.

I want to thank all of you who have come today. This hearing will be unique in several respects—I think it will be different than any you have participated in before.

We will start the hearing with some testimony from witnesses that we have identified who will talk about their individual circumstances. Those witnesses will be over on this side and you will hear from them first. Then we have three individuals, whom I will introduce later, who are health care providers and professionals in the Upper Peninsula who will be talking about the problems of health care requirements and unmet cost from that vantage point.

Then we are going to take just a brief break. It will take us about an hour to go through that part of the program plus some introductory remarks I will make that will set the stage for this.

We have a group here from Hancock who have been very kind to come over today—the Senior American Coalition. They are going to favor us with a little music. If you want something to look forward to you can look forward to that. I am looking forward to that.

Then we are going to take every person in the room that wishes to make a statement about the problem as they see it—either as they have experienced it in their own personal life or as they know about it from their own experience or if they have any other sug-

gestions or observation they want to make about what needs to be done in this health care area. We are going to stay here as long as it takes so that everybody in the room that wants to speak will have the chance to do so and become part of this official hearing record.

We are going to have a lot of seniors speak in the course of morning because we got lot of seniors here and that we have particularly asked to come. We had one senior that we had hoped would be on our initial panel this morning and at the last minute could not make it so we are going to be looking for testimony from seniors throughout the morning as we get to the opportunity for people here to speak. I know of one already who wishes to do so.

As you see we have two microphones here. When our two panels are finished, anyone who wishes to come up and make a statement will not necessarily have to stand at those microphones but can come and sit at the table where it is just a little more relaxed.

We have found in the other hearings and I think we will find here today that there's an awful lot that we need to learn and a lot people want to tell us and want to have heard. I don't want anybody to feel reluctant to speak. We're all friends and it's very important that we share the information that we have so that we really get a handle on the dimensions of what appears to be—and what I am convinced is—a health care crisis in this country.

We have a crisis both in terms of people who experience illnesses and have inadequate protection to meet those illnesses—in many instances those are senior citizens—but also people who are, for one reason or another, totally uninsured—they can't afford health insurance and don't have it either for themselves or their families and therefore are living with the danger each day that something can happen. An illness or an accident can strike and suddenly a family is plunged into an impossible financial situation.

Anyone who has thoughts they want to share that does not want to speak publicly can also do so. We will circulate to anyone who wants it paper and something to write with so you can actually write out a statement if you prefer not to speak directly. But I would hope that most of you who want to speak will feel comfortable to do so.

OPENING STATEMENT OF SENATOR RIEGLE

Senator RIEGLE. Now I am going to quickly set the stage for this discussion today with some basic facts about where we are in this problem in the country. I serve on the Senate Finance Committee. I have just gone on that committee this year. That's the committee that has the responsibility among other things for social security and for medicare and for the whole question of developing a catastrophic health insurance program for our country. We are working on that now. In fact we have produced a proposal that has been reported out of the Senate Finance Committee. I will describe it briefly in just a short time but I am here today to get your reactions to that and your sense for what else may need to be done.

Let me start first with senior citizens. All the evidence that we are seeing so far indicates that there is a major national problem with senior citizens today where there are huge gaps in the medi-

care coverage and that there are things beyond medicare in the health area that are hitting seniors in increasing numbers that are causing people to see a whole life time of hard work and savings used up in maybe a matter of just a few days or 2 or 3 weeks or a month or two of a serious illness.

We have heard of countless cases across the State of Michigan of that happening—of people who have been very prudent throughout their lives, put their money away, get hit with a major illness and even though they may be covered by medicare, the coverage is insufficient so that within the matter of a short time their life savings is exhausted. The only way they can get help beyond that is to qualify for medicaid and that of course means using up every last dollar virtually of your savings in order to qualify under our welfare system.

In some cases where there are husbands and wives who are senior citizen age, one becomes sick and remains ill for a long period of time and the bills are very high. Sometimes lawyers urge those couples to actually consider divorcing one another so that they don't lose all of their life's earnings and belongings in order to qualify for medicaid. Those kind of, I think, disgusting circumstances are arising because of the failure to really see what's happening to people. It's causing pressures and strains that are this extreme. It's just not right and it has to be changed.

We are finding that bills totaling $40,000, $50,000, $60,000 for a single major illness for someone who is in the hospital, and as I say find that every cent they have ever been able to put away is suddenly gone. So something has to be done about this.

Many senior citizens, and I will ask later for a show of hands as to your thoughts of this, have taken out what are called medigap policies and I know many of you here today would have medigap policies to try to provide insurance beyond what medicare presently provides.

What we are considering today in the Senate is additional catastrophic coverage under medicare that would apply to senior citizens and would replace much of the protection that you now are able to get by buying these private medigap policies. So if we are successful in actually enacting an expansion in catastrophic health care coverage under medicare, in ways I am about to describe, it would replace substantially the medigap policies and therefore you would not be required to continue those at least for that purpose.

President Reagan, to his credit, earlier this year came forward with a catastrophic health insurance proposal and that is what we have been debating in the House and the Senate. We started with that proposal and are now deciding how it might be modified, changed or expanded.

The President has laid down this requirement—he has said that any expansion in coverage of health care cannot be paid for by the government. It has to be paid for directly by the people involved so it has to be a self-financing system or he will not accept it. So we have to decide how we structure that kind of program, how it is to be paid for and then what the benefits are that can be provided at this point in time.

If we can get it adopted, the plan will provide broader coverage against these catastrophic illnesses. There will be an additional

cost in order to pay for these. The proposal that we have now developed in the Senate, based on the President's starting proposal, would provide coverage for acute illnesses for people on medicare. If you found yourself going into the hospital for some major medical treatment—a heart by-pass situation or stroke or some other major acute illness—and the bills are running up into the several thousands or even tens of thousands of dollars, under the new proposal the total amount that you would pay in a given year is a figure of $1,700.

Now $1,700 is not a small amount of money but in terms of trying to structure the program, where there is a catastrophic illness, the individual would be responsible for only that $1,700. Beyond that, any money required would now be covered by this catastrophic health insurance protection under medicare. So that if your hospital bills and your doctors bills in a given year total $10,000 or $15,000 or $25,000 or whatever the figure, the most you would pay would be $1,700 and the remainder of that would be covered by this new protection under medicare.

Now that also means of course that you would have to use physicians who accept medicare payments as full payment. As you know some do and some don't.

There is a small expansion of coverage for skilled nursing home care and for home health care and for hospice care but not a major expansion in that area.

The President's proposal had nothing on drugs or medicines—I am talking about drugs needed to combat illnesses and to try to get well—and we are endeavoring right now to put something in the proposal—of course we have got to figure out how to pay for it as well—that will deal with the question of covering the cost of medicine. We are finding and we may hear some examples today of people whose drugs and prescriptions alone can cost anywhere from $200 to $400 a month, just for the medicine to stay alive. So obviously if we are going to have any kind of a meaningful health protection system, that part of the problem is going to have to be dealt with as well.

In order to get that amount of additional protection, the way it would be paid for is as follows. If you are on medicare now, your monthly premium which is deducted from social security payments is today $17.90. Under the Senate proposal, that would go up by $4 a month, so there would be an additional $4 a month deduction from your social security to pay for this added catastrophic health insurance protection. Everyone would pay that.

In addition, because it's very expensive to provide this kind of health care coverage when catastrophic illnesses strike and because they do strike a lot of people, there would be a second supplemental premium. The supplemental premium would be paid on the basis of one's income, based on one's ability to pay.

It would start at zero and go up to as much as $800 a year for someone who might be earning as much as a $100 thousand a year or more, who is in the medicare group. Now obviously not a lot of people are in that situation but some are. But by scaling the supplemental part of the premium that way, 60 percent of the citizens of our country who are now on medicare would pay no supplemental premium at all. And if you fall into an income category where

your income is relatively modest in retirement, in all likelihood you would pay no supplemental premium. Only if you are really in a very strong financial condition would you pay a supplemental premium as I just described.

But bear in mind, for those of you who now have medigap policies that you are buying from private insurance companies to provide this same catastrophic illness protection, you would be able to discontinue those policies and not pay those premiums. So you would have a savings there to offset the cost of doing it through the medicare program.

Now there are some real limitations on this and I want to make sure that everybody understands this because it's fundamental in deciding what we should do now and what we should try to do in the future.

These proposals that I have just been describing deal only with health care for acute illnesses or for very extreme medical problems which is the current scope of medicare. It does not cover routine medical exams or dental care or eyeglasses or prescription drugs. And importantly it does not cover chronic, long term health problems that would require home health care or nursing home care. I am thinking about things like Alzheimer's or stroke or MS or lupus or severe arthritis or things of that kind.

You can have a medical problem that puts you in a situation where you require constant care that's different then having to go the hospital on an emergency basis. Today our system is not designed to deal with those chronic long term problems. If you have someone at home for example who is suffering from Alzheimer's and needs care all day long and it's not a situation that requires an acute hospital type of environment but needs either home health care or nursing home care, that is not covered presently under medicare, and it's not proposed to be under the plans we are talking about today. That involves another major step.

I want to be very clear about putting it on the table because I think the evidence that we are compiling shows that the need in that area is now so vast in this country that we have to get a debate going about whether we need to expand our health insurance system in order to reach the problems of home health care for people who have chronic illnesses or mental health problems and people who need to be in nursing homes.

Nursing homes today, by the way, on the average cost about $22,000 a year. A lot of times it's more expensive than that. And we've got a problem in the Upper Peninsula where we have a shortage of facilities, apart from finding a way to pay those very, very, substantial costs.

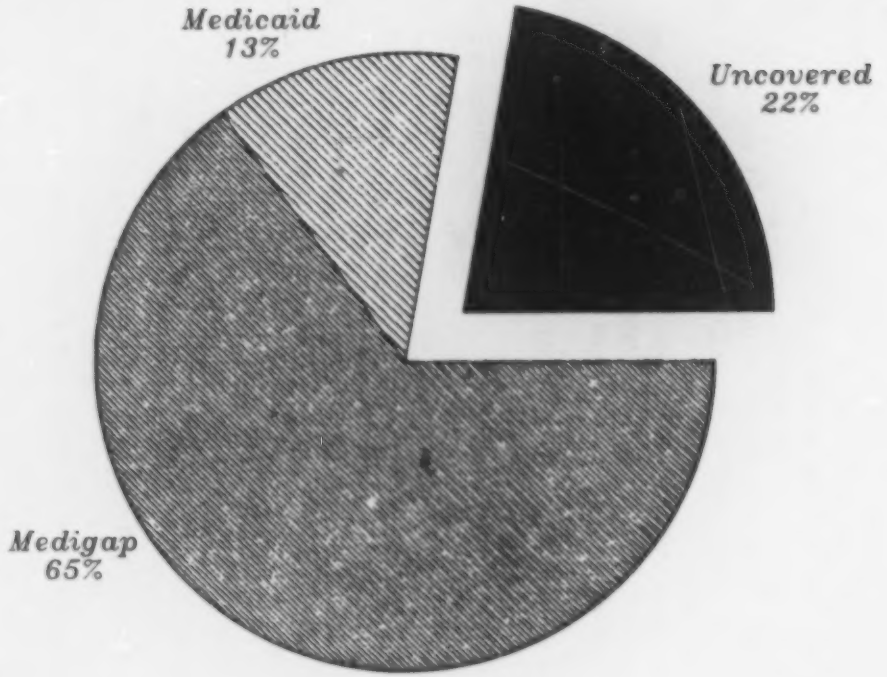
So it's very important to understand that medicare today is really quite limited in what it does and even if we extend it out to pick up these catastrophic illnesses that require hospitalization and involve huge medical bills, we are still not reaching the issue of long term home health care for chronic illnesses or for nursing home care. And people today in many cases don't understand that and think that when retirement comes and a person's on medicare, that medicare will automatically cover those things. It's a terrible shock when the time comes and people learn that medicare doesn't cover this kind of care and pretty soon their savings are exhausted.

Then there is this humiliation when they have to strip off all the assets of a life time and basically go on welfare.

So we've got a problem here where people of very substantial financial means, who have lots of money, can obviously afford the best medical care that's available. People at the bottom of the economic scale who qualify under medicaid receive financial help for nursing home care and help on these other catastrophic illnesses. It's the people in the middle, the average working person in this country, who today is sitting in an exposed position.

I want to show you two charts on this, then mention one other thing, and then we will go to our first witnesses. Joan if you will help me here. The young woman with me here is Joan Huffer who assists me on the Senate Budget Committee. She has come to be present and a part of this hearing today.

CATASTROPHIC HEALTH CARE COVERAGE FOR SENIOR CITIZENS



Office of Senator Donald W. Riegle, Jr.

This chart that I have here—and I hope everyone can see it, I will try to move it around—illustrates in a graphic form a summary of what I have been saying. In talking about catastrophic health care coverage available for senior citizens today, we are talking about these acute illnesses—my father had heart failure and was taken to the hospital and ended up having five by-passes. His is just one case of thousands that might be cited.

Today, 13 percent of the costs of that kind of acute care is paid for because people have gotten themselves in a welfare situation and are being helped by medicaid.

Twenty-two percent are uncovered. They have no kind of protection at all today, outside of medicare. So this extension the President and the Congress are working on would solve this problem where there is no protection from bills above and beyond those covered by medicare.

This blue area represents people with acute catastrophic health care costs—this is for senior citizens now—but this number of people in our society have taken out these private medigap policies. In fact how many here that are in the senior citizens group today in this room have some form of medigap policy. Raise your hand. [Audience complies.]

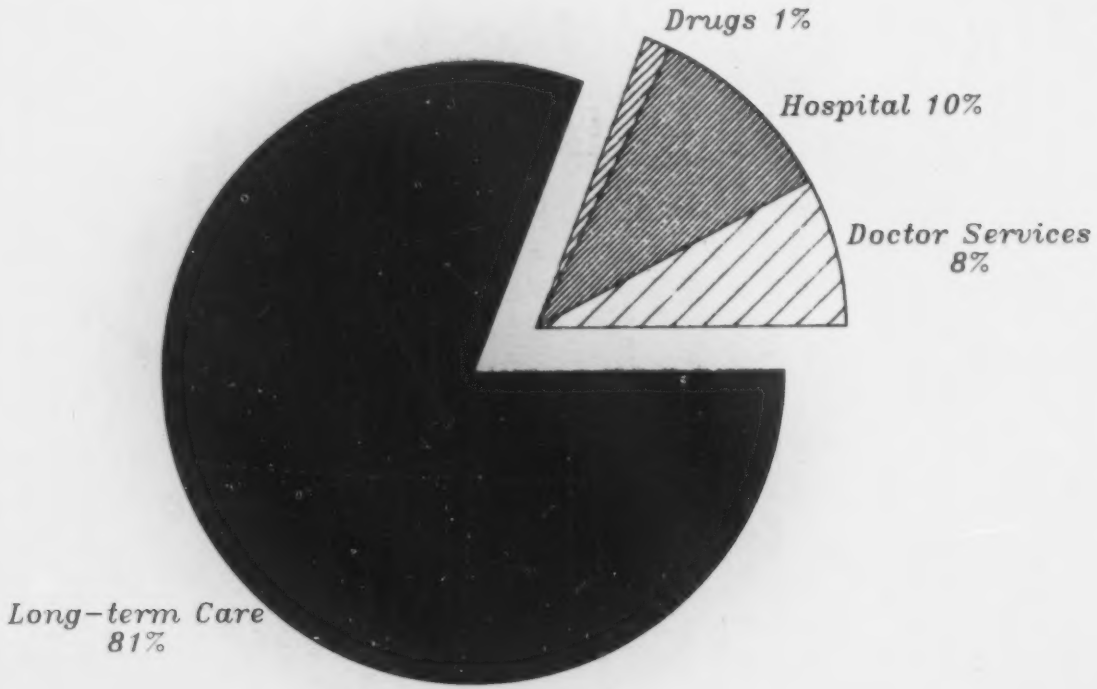
As you can see from looking around the room there is a very substantial number, probably at least a third to 40 or 45 percent of the room. So you would be in this area. You are paying now a supplemental payment in order to protect yourself against these catastrophic costs.

This proposal that we are talking about in the Senate would provide that protection to you now, or would in the future, under Medicare. You would have to check your Medigap policy, but basically the presumption is that you would be able to discontinue that because you would now be getting that protection through the medicare system.

Of course these people, many of whom are seniors who can't afford the supplemental coverage, or don't understand the need to have it, they would also be covered. So everybody in this group and this group would be covered under the extension of the plan as we are talking about it.

The other chart I wanted to show you here however is this. We need to think about the long term health care costs for senior citizens in the country—and God willing, if we all live long enough to have the privilege to be senior citizens, we'll all be there someday so we had better think about it not just for our parents and our grandparents but because this is something if we are fortunate we will all live to see ourselves.

CATASTROPHIC OUT–OF–POCKET EXPENSES OF THE ELDERLY



Office of Senator Donald W. Riegle, Jr.

In terms of the cost of both these acute illnesses and these chronic health problems that go on month after month and year after year, if you look at the costs that seniors pay out of their own pockets for just the hospital-type illnesses, it is just this blue fraction here. One percent tends to go for drugs and medicines, about 10 percent goes for hospital bills and about 8 percent for doctor services.

Now that's a lot of money in the aggregate, but this huge red block here represents the part that today is totally outside medicare, and that's long term care. Whether it's long term care in a nursing home or long term care in your own home, where you are ill and need regular attention, you can see the amount of money people spend out of their own pockets today versus the amount spent on acute illnesses that require hospitalization and intensive work by doctors.

So while this acute care problem is big in and of itself and is the one the government right now is trying to deal with, it still leaves this problem of long term care for us to recognize and think about and decide to what it means to us and what we ought to consider doing about.

Now some people say it's time for us to begin a debate about some kind of additional step in a national insurance system, some kind of national health insurance system that could spread the risk across the whole society, where all of us would contribute something, so that those of us needing that long term health care in a nursing home or at home because of a break down of our health would be able to have those bills met without having to go into poverty or literally to find that you are in a helpless situation because there just isn't the money to pay it.

I think the time has come for us to began in a serious way to focus on what this part of the problem means to us and what we should do about it. I hope some people speak to that today. I know I will as the morning goes on.

Now I want to touch on one other subject. We've talked here about medicare and we are talking about senior citizens. I want to talk also (let me just put this back here) we also have witnesses today and the focus of this hearing also on people of other ages beneath the ages of senior citizens who are both uninsured or underinsured.

We have some 30 to 40 million people in the country, which is roughly 15 percent of our population today, that have no health insurance whatsoever. It can be a young family, it can be a young individual, it can be somebody who is 40 or 45, married, divorced, widowed in that situation that has no insurance at all. So if something happens, an accident happens or an illness strikes they have no place to turn, they have no protection other than what they have in their own savings. Most people in that situation who have no insurance don't have much savings. That's one of the reasons why they are not able to afford the insurance.

It's estimated that there are another 75 million Americans that are under the age of 65 that are seriously underinsured and I will show that just here in a minute. It covers all regions and all age groups. It's a major problem and we are finding that because the cost of health insurance is going up that the number of people in

the society that don't hve health insurance is increasing dramatically. It's up to about 40 percent just since 1980. There are about 5 million Americans that now report that they do not seek health care at all because they are unable to pay for it. And we hear from individuals who will not go to the doctor except in extreme emergencies because they can't afford to pay the bills.

Now this is a serious national health problem, I think, not just for the individual involved but because, in the end that, person's unmet needs becomes a problem for our country and for all of us as a society. It is a problem both in terms of the ethic of caring about one another but also the fact that these unmet health needs usually turn into something serious and so finally when they are dealt with, we probably have a much more difficult and expensive problem to have to solve.

Even if it's going to be solved by medicaid under a welfare system, the cost may be much much higher and an awful lot of suffering has gone on in the mean time. It seems to me that that's absolutely pointless.

So we have a number of proposals that have been advanced as to how to provide some measure of health insurance for uninsured persons of all ages. We are finding that more and more people are going into service industry jobs and a lot of those jobs in the service industries, at fast foods places and so forth, do not carry with them the health insurance benefits that we have seen in the past when people have worked in manufacturing companies or mining or some of the other areas which had a habit and history of being unionized and where health care benefits were a part of the package that was negotiated. We are finding that this is less and less the case and so this question of finding a way to provide health insurance for individuals who today don't have it is another major issue.

I am not going to get into the details now. Ted Kennedy has produced a bill in this area. I have produced a bill that works in a slightly different way. I will just summarize that as well with this chart and then we will go to our first witnesses. Joan if you will help me one more time here.

EMPLOYMENT STATUS OF UNINSURED INDIVIDUALS

12 million (34% of all uninsured) of above dependents are children.

Office of Senator Donald W. Riegle, Jr.

If you look at the employment status of uninsured people today what you find is that 69 percent of the people today who are uninsured are either individuals or the dependents of individuals who are working. I think there is a presumption today that people who don't have health insurance are people who are unemployed. Well there are a lot in that category, but in fact, by far the lion's share of people in the country who don't have health insurance are nevertheless working. But they don't get it with their job or they don't make enough money to be able to pay for the health insurance premiums. So of all the unemployed people in the country today this portion are actually working and about 31 percent or 11 million are not working.

It turns out that 12 million or 34 percent of that whole group who have no insurance are children. Children run into all manner of problems not only with diseases and illnesses but accidents as well and they are not always protected under our health system as it stands.

In terms of the family income of the individual families that have no health insurance today it's interesting to note that 365 percent, the red zone, are below the poverty line, and 17 percent are what's called near poverty. So about half are basically in poverty circumstances.

Family Income of the Uninsured
(Under 65 Years of Age)

Office of Senator Donald W. Riegle, Jr.

But the other half, another 13 percent are classified as low income and actually 35 percent, a full third of the people in the country who do not have health insurance, are actually earning what is called a middle income. But it obviously isn't enough to meet the cost of health insurance today if you have to buy it privately for yourself and for your family.

What we are finding is that if you have it in mind that it's just unemployed people who don't have 5 cents who don't have health insurance, that's not the case. We are finding out that there are a very substantial numberr of people in the country who are working very hard every single day to sustain themselves and are earning at least in a third of the cases what we would call a middle income amount of money but still are not able after meeting the other needs to come up with the money for health insurance for their family. So we've got a major problem of a lack of insurance in that category as well and we will hear somethings about that today. I hope I haven't taken too long but I wanted to set the stage here for the other things we are doing to hear today.

Let me now introduce our first three witnesses and then I am going to ask them to speak directly. Our first witnesses are people who have encountered catastrophic health problems first hand and they can tell us about the kinds of problems that arise when health coverage is not available or is not sufficient to take care of the health care expenses. It is not easy to talk about these problems and I really thank the people who are willing to talk about their indivdual situations and others later in the morning in the audience who will also talk about problems in their families that they have experienced.

These are very sad situations in many cases and they are very hard to talk about. But it's vital that they be talked about because I think we have to get the truth out on the table about what's happening. We've got to get it assembled so that we understand what's happening to us as a society so that we are in a position to take intelligent and humane steps to see that we do what we should do and we decide what we want to do collectively.

So our first witness will be Pamela Talano who is from Marquette. Pam has had experience with traumatic brain injury. Her husband has suffered from what is called TBI, traumatic brain injury. She formed the UP Head Injury Organization and will be testifying on behalf of Mr. Jack Wirth, who has suffered that kind of injury.

Next, we will hear from D. JoAnn Johnson from Loretto. JoAnn was diagnosed as having a severe heart condition. Because she has no health insurance she was initially refused treatment but has since had to get care for her condition and she will tell us about the struggles that she has faced to meet these medical costs.

Finally, we are going to hear from Dr. David Boyd from Marquette. David is a quadriplegic as a result of a spinal cord tumor. He will tell us about his experiences in trying to find the resources to provide adequate quality care for himself and others in his condition.

We had a senior who was part of this panel that was not able to come, but we will hear from a number of seniors before the morning is out because it is very important to have that as well. With

that, Pamela, let me call on you. We would be pleased to hear from you at this time. Thank you for coming.

STATEMENT OF PAMELA TALANO, MARQUETTE, MI

Mrs. TALANO. Thank you.

My husband, Anthony Talano, suffered a traumatic brain injury (TBI) caused from an auto accident in which he was a passenger in May 1984. For 3 years we have struggled with various public agencies, attorneys, insurance companies, physicians, hospitals and therapists. Through very rate opportunities Tony was able to overcome his injury and return to the productive work environment he's known for 20 years.

It is because of his injury that I became involved in the betterment of life for those who have suffered TBI. Specifically, I am advocating the need for and adoption of a catastrophic health care bill.

This testimony is on behalf of those with TBI who are in desperate need, more specifically, Jack Wirth and his family.

Jack Wirth, of Trenary, MI, worked hard for 25 years, the last 9 with Kimberly Clark Corp. in Munising, MI, to support his wife, Pat, and two sons, Jack, Jr. and Tony. His hard work resulted in a comfortable, but modest lifestyle for his family.

Then, on February 23, 1986, all of his hard work and his family, as he knew it, was destroyed. He was thrown from his snowmobile while riding with his sons and a brother-in-law. For the next 30 days Jack lay in a hospital bed in ICU, fighting for his life.

While hospitalized for the next 5 months, Jack went through extensive rehabilitation to relearn the skills he had lost in his brain functions. In August 1986 Jack's physician and treatment team felt he needed more intensive rehabilitation at a facility specializing in TBI. Jack's insurance, however, would not fund such a program.

Jack was confined, unnecessarily, in the hospital for 7 more months because the insurance company would pay for Jack's rehabilitation only as long as he was an in-patient in a hospital. In total, Jack was in the hospital for 13 consecutive months.

During the time of Jack's hospitalization, his wife, Pat, drove each day to Marquette to be with her husband. Also during this time she contacted every possible source of assistance for Jack. To date, she still struggles for appropriate care for Jack.

She contacted her local Social Service Department because the household no longer had an income. The Department of Social Services told Pat she was ineligible for financial assistance because the family had too many assets.

She then contacted the Veteran's Administration because Jack had served in the Navy. She was told that because Jack had not been hurt during active duty and had not served during wartime, he was, again, ineligible for any benefits.

She applied for medicare and was told that no person is eligible for medicare benefits for a minimum of 2 years after a disability.

At this point Pat's frustration was building as was the emotional stress and the fatigue. The family's only assistance came from social security. Jack is receiving social security disability payments

monthly in the amount of $702 plus an approximate $10 cost of living increase.

The monthly bare expenses excluding home heat and groceries for the Wirth family is $580 a month. Jack's son, Tony, 17, also receives $355 monthly, which so far, has had to be applied to household expenses.

Jack is also ineligible for benefits under the Michigan Auto No-fault law because his injury did not occur in an automotive vehicle accident.

When applying for medicaid through social services, Pat was told the only way medicaid would pay Jack's bills is if Pat were to put her husband in a nursing home.

It is evident that the stresses and strains on a family unit associated with TBI can be devastating. However, when coupled with the frustration and desperation of not having appropriate care for a loved one, surviving this kind of trauma is nearly impossible. It is estimated that 80% of families where a spouse has been injured ends in divorce.

Jack has been discharged from the hospital and home for 5 months now. Pat still drives Jack to Marquette 3 days per week for outpatient therapy, 20 percent of the cost of which the Wirths have no insurance coverage at all. Currently these bills are being stacked up at Marquette General Hospital not being paid.

The daily battle in the Wirth family lessens the physical and emotional strength of the family unit and breaks down the tolerance, resilience, endurance, and the perspective of the primary care giver, namely Pat Wirth. Pat has sought professional psychological help in coping with these problems but was unable to continue her therapy, again due to financial difficulty.

The out-patient services with which Jack is currently being provided fall short of his overall need and make reaching his potential impossible. Given that, his current treatments are still unaffordable and causing long-term debt and, indeed, poverty for the Wirth family.

All of the financial "brick walls", costing Jack his future and potenitally his family, could be avoided with a catastrophic health insurance plan. Where brain injury is concerned, there is no time to endure the 2 year waiting period for minimal medicare coverage. It is a proven medical fact that time is of the essence in the recovery process with TBI. The first 2 years after traumatic brain injury are critical in saving healthy, teachable brain cells. With catastrophic health insurance, people like Jack Wirth could, immediately upon diagnosis, be on their way to a recovery plan that meets their needs, thereby giving them a better prognosis for a productive lifestyle.

Furthermore, the country's social programs and, thus, the taxpayer, would save thousands of dollars in the long run, if we could get people like Jack Wirth back to work. Jack Wirth's disability alone, over a lifetime of social security payments, insurance reimbursements and lost wages surely are much more costly to this country than adequate initial rehabilitation.

As president of the Upper Peninsula Head Injury Organization I challenge you, Senator Riegle, to help in this matter. Help this

country, the richest in the world to prioritize its spending policies. Give the citizens of America a little return on their investment.

We need catastrophic health insurance for Americans of all ages. I realize the problem is very great for senior citizens but there are so many in this country like Jack who will never be a senior citizen without the proper health care coverage.

Three years ago the statisics on brain injury were between 50,000 and 70,000 people in this country every year suffer traumatic brain injury so severe that it prohibits their return to work. Of these 50,000 to 70,000 people only one in 20 are getting the proper care. Nineteen out of 20 people are falling between the cracks because they can't get help.

Pat Wirth's income is $8,000 a year. That is indeed below the national poverty level or pretty close to it and she's not eligible for any assistance because she has too much money. Jack is 1 of 19 out of 20 people. He is not a unique case. There are lots more like him. Thank you.

Senator RIEGLE. Thank you. Thank you for coming and telling us that story. These are not easy things to talk about, that's for sure.

[The prepared statement of Patricia C. Wirth on behalf of her husband Jack follows:]

August 21, 1987

To Senator Riegle:

This testimony is on behalf of my husband Jack Wirth and others with Traumatic Brain Injury.

Jack was in a snowmobile accident on February 23, 1986 and sustained a severe head injury, he was hospitalized from the date of injury untill March 20, 1987. Jack is now receiving out-patient therapy three days a week.

Even though our medical insurance has paid hospital bills and most all of the doctor bills, my husband has not received the rehabilitation recommended to us by his doctor and therapists. Our insurance will not cover the cost of a facility specializing in brain injury, nor will Medicare when Jack becomes eligible, nor will Medicade if he becomes eligible for that.

It's an agonizing situation to know what my husbands needs are to reach his full potential and have no way of realizing them because of the costs involved.

When Jack was discharged from the hospital it was not because he was well and ready to come home, but because our insurance only covers for a certain length of time. The only alternative would have been a nursing home and this was out of the question as far as I was concerned.

With the help of our two sons, Jack,Jr. and Tony we have been doing what we can for Jack at home, which entails constant supervision and trying to help him relearn and remember all that was destroyed because of the injury.

I have tried every agency that I know of looking for help but so far to no avail. The trauma of this situation sometimes seems more than I can handle. It scares me to think of the consequences to Jack if there comes a day when I can no longer care for him.

It is because of Jack's injury that I am asking you, Senator Riegle, to please do everything you can to see that everyone with the need receive catastrophic health care insurance.

Sincerely,

Patricia C. Wirth

Senator RIEGLE. JoAnn, should we hear from you now? I am going to ask too, we have got a number of people that have indicated a desire to speak as the hearing goes along. I would like to add a senior to our panel here to replace the one that was not able to come. So if someone has a very compelling story to tell about your family situation or husband or wife that you have been through that really illustrates what happens here—that gentleman right there—we will have you come up right at the end of this panel. Excuse me, JoAnn.

STATEMENT OF D. JOANN JOHNSON, LORETTO, MI

Mrs. JOHNSON. I first became aware of a heart problem when I entered the hospital in Iron Mountain on February 9, 1987. I had no idea that's what was wrong with me. I thought I was going in for a simple gallbladder operation.

The next day I was rushed to Green Bay and they did heart catheterization, found out that I needed five bypasses. And at first I was really extremely upset about that because we have no insurance. My husband had insurance—I had insurance but when my husband became disabled we had to drop it because we've had only the income that I make as an elected township official since 1984 which is less than $5 thousand a year.

So I did refuse the operation and so my husband had quite a time I am sure that night living with my decision and the next morning I decided I would have the, the doctors talked me into it, even though I couldn't afford it. And I did have the operation and I left the hospital early—on only 6 days after the operation I left.

But, this resulted in bills totaling—there were 16 different health care providers and the bills totaled $26,102.27 to date and they are still occurring because I still need care. But if I have to go back to the hospital, who is going to take care of me?

I don't know what will happen with me now because we have tried getting help to pay these bills from social services in the county, the State, the Veterans Trust Fund, Federal. I am too young for medicare. I don't have any dependent children so I can't get help from the State with Aid for Dependent Children who usually get a medicaid card. So I don't know what will happen.

And I think this country really needs a national health insurance program of some sort possibly funded the same way social security is funded because more and more people are falling through the cracks as you mentioned.

They're either not getting—most of them are working and like you said they can't afford the insurance. They're not covered under their place of employment. And I know, off hand I know about four or five different people that are in a similar situation I am, and I feel that I am really one of the lucky ones.

So I do think that this is what's going to have to happen because who's going to decide who's going to live and who's going to die.

After all, when I was in the hospital it was pretty hard to refuse to live. I feel that, you know, that we should have something that everyone could afford. I'd be willing to pay out of my tiny wages commensurable to what I can afford. And all we own is our home and we raised nine children. We own a car, we own an old snowmo-

bile and we own an old motorcycle—they're all over 10 years old. So our assets are not great after a lifetime of work. And I thank you.

Senator RIEGLE. Well, I thank you for your personal example and I thank you for coming and sharing this with us.

[The list of Mrs. Johnson's medical costs follows:]

LIST OF INDEBTEDNESS DUE TO ILLNESS (TOTALING $26,102.27)
(EMERGENCY OPEN HEART BY-PASS SURGERY)
OF

D. JoAnn (Mrs. Ernest M.) Johnson
Box 72, 227 Dean St.
Loretto, MI 49852
(906) 563-5242

From January 30, 1987 through April 30, 1987

1. David E. Atkinson, M.D., P.C.
500 Main Street
Norway, MI 49870
$45.00

(Office Calls on January 30 and February 2, and for drawing blood.

2. Continental Bio-Clinical Laboratory Service, Inc.
P.O. Box 2968/2740 28th St. S.W.
Grand Rapids, MI 49501-2968
(Blood test) $60.40

3. Dickinson Memorial Hospital
400 Woodward Avenue
Iron Mountain, MI 49801
$1,643.60

Entered emergency room about 2:30 a.m. February 9, 1987, was transferred to St. Vincent Hospital, Green Bay, WI, after 8 hours.)

4. Dickinson County EKG Readers Assoc.
P.O. Box 811
Iron Mountain, MI 49801
$$36.00

5. Radiology Asso. of Iron Mountain
P.O. Box 370
Iron Mountain, MI 49801
$13.00

(Chest X-Ray)

6. Dickinson County Ambulance Service
County Correctional Center
Iron Mountain, MI 49801
$352.00

(Transfer from Dickinson County Hospital, Iron Mountain, Michigan to St. Vincent Hospital, Green Bay, WI, a distance of 100 miles.)

7. St. Vincent Hospital
P.O. Box 13508
Green Bay, WI 54307-3508
$3,066.95

(Critical care from February 9 through February 11, 1987, plus use of heart catharization room and equipment)

8. Bellin Memorial Hospital
P.O. Box 1700, 744 S. Webster Ave.
Green Bay, WI 54305

$13,177.00

(Hospital stay from 2-12 through 2-18 due to open heart by-pass surgery)
March 18, 1987-blood tests, EKG and X-ray $79.30

April 9, 1987 (stress test) 292.00

TOTAL OWED BELLIN: $13,548.30

9. Consulting Surgeons, LTD
704 S. Webster Ave.
Green Bay, WI 54301

(Dr. John R. Soeter, M.D. $3,400.00

10. Rodney H. Sathoff, M.D.
2825 N. Mayfair Rd.
Milwaukee, WI 53222-4470

(Anesthesia Service) $1,855.00

11. Cardiology Associates of Green Bay, LTD
704 S. Webster Ave.
Green Bay, WI 54301

(Dr. Lewis G. Anthony $907.00

12. Green Bay Clinic, LTD
123 N. Military Ave.
Green Bay, WI 54303-3299

(Coronary Artery Bypass Graft-Sin) $805.00

13. Radiology Chartered
P.O. Box 3006
Green Bay, WI 54303

(5 chest X-rays between February 11 & 18, 1987) $60.00

(X-ray March 18, 1987) 17.00

14. V. Mahadev, M.D. F.A.C.C.
200 Fairbanks St.
Iron Mountain, MI 49801

(Admitting physician 2-9-87 & office calls 2-23 & 4-27, 1987) $121.00

15. Hospital Diagnostic Services
1121 N. Lynndale Dr.
Appleton, WI 54914

(Stress test on April 9, 1987 $126.00

16. Chick's Snyder Drug
1400 S. Carpenter Ave.
Iron Mountain, MI 49801

(Drugs from 2-18 through April 30, 1987 $46.28

GRAND TOTAL THROUGH APRIL 30, 1987: $26,102.27
NUMBER OF SEPARATE BILLINGS: SIXTEEN (16)

Senator RIEGLE. Before I go to Dr. David Boyd, Pam, let me just ask you, can you give me a rough sense of what the bills were that you experienced when your husband initially had his traumatic brain injury, or could you give us a rough sense for how much Jack Wirth's bills would be that he has accumulated from the start of his problem.

Mrs. TALANO. I am afraid that I don't have the figures with me. They are in the portfolio with my testimony. I believe the rough figure for Jack Wirth is approximately to date about $120,000.

My husband's bills—I don't have an exact figure on because I am not a CPA and I think that's what it takes to keep this kind of a thing straight. But my husband's bills are somewhere in the vicinity of $800,000.

Senator RIEGLE. You know what's so striking about both of these cases—here are two families who are going along. In the normal course of events, in one case an accident happens, a terrible accident and in the other case a health problem arises. There was no reason to think that you had a serious heart problem. You went in for something else and they found out that that's what you had and it was either probably a choice between getting the five bypasses or not living much longer.

Three months they were going to give you to live at the longest if you didn't have the surgery. My father was the same way—when he got his five bypasses and we went to get the operation he almost couldn't walk from the plane to the door of the airport to get into the car to go to the hospital because he was down to less than 5 percent of his heart capacity through his arteries. It sounds like your case was similar.

Mrs. JOHNSON. I had from 99 percent down to 50 percent of my arteries. They were—all five of them in my heart—were closed between 99 to 50 percent.

Senator RIEGLE. Well I hope that you are going to keep plugging because I think we are going to find an answer as the evidence continues to pile up. I wish you could all hear what the witnesses have said at the other hearings we have had. When we get this whole hearing record produced you will be able to go through it and see that there are not isolated cases, that this is happening to more and more people all the time. It's just that the problems don't see the light of day because everybody is suffering by themselves or within their own family circles.

Unless we collect all of this and get it out in the open where we can see what's happening, this is the kind of broad national problem that can be ignored for a long, long time while people's lives are being literally being destroyed.

Mrs. JOHNSON. And it's very demoralizing too, to have to tell people that you don't know how you are going to pay them because no way would I have gone out and run up $26,000 worth of debt, you know. But when it comes to a matter of life and death, then, you know, how are they going to make the decision if you are right there? Are they going to say, "Well, pull the plug," or are they going to say, "We refuse to take care of you," and are you going to say, "No, I don't want to live anymore?" So it becomes quite a problem in this country.

Senator RIEGLE. Well, we're here to get the facts out. David.

STATEMENT OF DAVID BOYD, MARQUETTE, MI

Dr. BOYD. Having watched a bit of television lately, if you will pardon the indulgence, I just wanted to say at an official Senate hearing I cannot remember ever having seen the document. [Laughter.]

My name is David Boyd. I am 46 years of age and live in Marquette, in a special housing complex for physically handicapped people. I am a quadriplegic due to a spinal cord tumor.

In 1968, I lived in a rural town in the midwest. I had a college education, a decent job, was married and had two children. We were saving up for a down payment on a house. I also had a recurring pain in my neck.

By 1969, I was paralyzed, divorced, unemployed and had moved to Michigan to get personal daily care and maintenance from my retired parents. At the time, my father had the very early stages of Alzheimer's disease which made daily routines anything but routine as time wore on. The stress of Alzheimer's disease continues until today with my mother bearing the load.

Since 1969, I have worked as a community volunteer for handicapped people's causes. I have focused most of my energy on getting a facility constructed which would provide affordable, safe, barrier-free living for physically handicapped people. In that effort with the help of you, Senator Riegle, the State of Michigan and others, we succeeded.

The Propylon non-profit housing corporation apartment complex opened last year in Marquette. The building, however, addressed only half of the problem. Severely physically impaired people need daily living assistance in order to stay healthy and avoid nursing home or institutional placement. Trying to find good competent care givers is difficult at best. Even mediocre care can be extremely expensive.

There is a severe lack of financial support from either private or public sources for daily living assistance. For the typical middle class person who has tried to save some money for a rainy day and is hit by a flood, the savings either disappear in a twinkle or they preclude eligibility for the existing support programs such as medicaid.

During the time I stayed with my parents, they helped me save money by deferring room, board, and care costs. These savings later prevented me from receiving help from the Department of Social Services. I manage without DSS assistance, but know that I really should have more care time than I do.

However, even if a person does qualify to get help from DSS, from what I see going on at Propylon, the problems continue to exist. It seems as though Department of Social Services does not have enough money to pay for adequate levels of personal care. Its staff spends time and energy figuring out ways to decrease the amount of money severely physically handicapped people get for this purpose.

In Michigan the DSS program which is designed to aid people in staying independent is called home help or chore service and is limited to $333 per month. Amounts over this figure are called payment exceptions and are legend within the handicapped communi-

ty in terms of the difficulty of getting them and the even greater difficulty of keeping them.

Three out of four of the residents who receive payment exceptions where I live are either complaining about the inadequate amounts or are appealing cuts. The consequences of inadequate home help are deadly serious for paralyzed people. For example, one of my friends has experienced a series of urinary tract infections during the past year, attributable largely, I believe, to his home care exception payments being insufficient to pay for proper liquid supply and catheterization. Little is said when he goes into the hospital on medicaid to get antibiotics, enough to drink and regular catheterization although the cost for that is outrageous compared to what it would be for proper care at home.

Perhaps the reason behind this lies in the source for funds in question. Exception payments are primarily State money whereas Medicaid payments are federally based. This, I believe, supports my contention that the Michigan Department of Social Services would not particularly object to their clients leaving our housing complex and going into nursing homes—not because it would be better for them, because it wouldn't—but because it would mean that the funds would come from a federally lined pot.

Furthermore, the proper management of chronic conditions in the home often requires preventive services such as physical therapy and occupational therapy. However, the only way to get these services paid for is through medicaid or medicare. You must be poor to get medicaid and you must be sick enough to qualify for skilled nursing care to get medicare home health services.

I have no doubt that I could benefit significantly from physical therapy and occupational therapy. But, because I have only been in the hospital once during the past 12 years, I cannot qualify for those services.

I would like to propose that the answer lies in the establishment of an entitled national standard for home based personal attendant care along with Federal money to implement its uniform application. This should redirect the State DSS employee's efforts into finding ways to help people stay out of institutions rather than concentrating as they now do on pushing people down to what is referred to as the risk threshold.

Such a uniformed national standard would not only result in more appropriate, more humane living arrangements. It would result in significant savings of public expenditures. At any rate, the way things are now in this country, you must be either very rich or very poor for long-term care.

In summary, I would say that a devastating illness does much more than damage your body. It overwhelms your family with unrelenting care burdens, it brings financial ruin, it diminishes dignity and self-worth, and it breeds a cynical resentment toward a government which does not do all it can to lessen the evils attendant to a catastrophic health problem. The United States of America needs to move swiftly to provide for the common defense against this home front enemy. Thank you.

Senator RIEGLE. Thank you very much. I think we ought to give all three of these witnesses a round of applause for what they have had to say today and coming to say it. [Audience applauds.]

David, thank you very much. Let me now invite the gentleman whose hand was raised. Can you come on down, please, if you would.

Let me say that we have about three hundred people here in the room. I think this is an incredible showing of citizen interest and concern about this problem. To have this kind of turnout midday on a Friday is just tremendous. I thank all of you for being here and I think your presence underlines the urgency of these issues.

I am delighted to see you, and I am going to ask you to come as close to the mike as you can. This is Mr. Secord. He just gave me some good advice. He told me to take care of myself. I am going to ask you to speak right into that mike when you start because I want everybody in the room to hear you.

STATEMENT OF THOMAS SECOR

Mr. SECOR. This letter was written by my daughter about a week ago and it concerns my wife's illness. This is from—she wrote:

> From July 3, 1986 to June 7, 1987, my mother, aged 88 was an unhappy resident of the Shadylane Nursing Home in Manitowoc, WI, 275 miles south of Calumet. Because of fall at home, she required nursing home care while she recuperated. The nearest available bed was Iron Mountain, half way to my home in Manitowoc. So it was logical to care for her there—Manitowoc. My father, aged 92, remained alone in Calumet until Thanksgiving when we closed the family house for the first time in the winter and he moved to Manitowoc and returned in May 1987.
>
> The refrigerator motor, because it was shut off during the winter, could not be repaired—it was impossible—so we purchased a new one—$873. Bathroom plumbing in many places upstairs and downstairs required replacement of pipes and toilets—$894. Emotional trauma to our family cannot be measured in dollars can it? We feel that my mother's recovery would have been much shorter if she could have been in her own area and especially her friends could have visited and encouraged her. Many months of depression and rebellion. She even refused to eat and was spoon fed and needlessly confusion could have been avoided if a nursing home had been available in the Copper Country.
>
> Our prayer and sincere hope is that Michigan has turned towards her precious seniors to reach out to what they need—a helping hand.

Now, on top of that, I have the bill from Shadylane Home where she stayed, from 1986 in July to June the first in 1987. The total bill there was $11,337.95. Then on top of that there is ambulance fees—$495, drugs—$539, physical therapy—$145, plumbing fees—$894 and refrigerator $873 which, those last two items were unnecessary if I had stayed at home. And a total comes to $14,285. If we had a place up in the county that could have been all spent up in here and I and my wife would have felt a lot better being at home. Thank you.

Senator RIEGLE. Thank you for coming and telling us that and sharing that with us.

I want to relate to you one other story and we may hear one like that today, but I am reminded of it by some other things that have been said today. At one of our other hearings at one of our other locations in the State, we had a man come who was in his early eighties. He told the story of how his wife had developed Alzheimer's a few years ago and how he was struggling to care for her now in their home. He was trying to make ends meet and to look after her so she wouldn't hurt herself. He didn't want to be forced into a situation where he would have to exhaust all their assets to put her in a nursing home where he was convinced that she

wouldn't get the kind of care that she needed and probably wouldn't last very long if she were there.

But he described this situation where at night they sleep together and he has to sleep with his leg right next to hers because she has a tendency to wake up in the middle of the night. She does not sleep very long and she will get up and not know where she is or what she is doing. He is very fearful that she will hurt herself. So he has to lay right beside her so that the minute she wakes up, it wakes him up so that he can look after her.

As a result, he not only is providing her care all day long but is on call in a sense all night long. When he came to the hearing you could see the toll it was taking on him. As I say he was in his eighties. He was obviously a very strong man but he was worn down to the absolute ends of his energy and emotional strength and capacity. He was saying this is an impossible situation and I am doing everything I can to try to try to cope with it but it was obvious that that situation can't last. It's going to break his health.

I have forgotten which hearing this was in but there was a very large crowd of people there and as we all sat and listened to that man's story—which could be our story or the story of someone in our family—I think there was a sense throughout the room of a kind of outrage.

Something's wrong when these kinds of things happen to people in our society who've worked and contributed all their lives, done everything they could to build the country and to try to contribute and carry their share of the load and look after themselves and then find themselves in these incredible health situations, way beyond their capacity to help. And then they find that the whole governmental system is almost designed against helping them get some kind of decent, humane answer to the problem, both for the person who has the illness and the other who is responsible for trying to help that person. And it really doesn't have much to do with age—it could come at any age. We've heard examples here already this morning, just in these four cases, of catastrophe striking at virtually every age level.

So I think we do have to ask ourselves these questions. We have a debate right now on in the Senate and in the Congress about whether we are going to go ahead with the Star Wars program. Now the Star Wars program costs a trillion dollars. A trillion dollars is a thousand billion. It's a lot of money. That's just one of the competing priorities on the table today and there are a group of people that feel very strongly about the need to do it. Another group feels very strongly that it's a waste. I happen to be in that group—you might get a sense for that.

But for a tiny fraction of a trillion dollars, we could have a system that dealt with all of the catastrophic health needs in this country. We could have it because we are going to spend the money anyway on these other things. And we are a Nation of very substantial means. This isn't to say that we don't have problems—we do have problems. We all know that. Some of them are financial.

But we are making good progress as a nation and we can afford by one means or another to craft an answer to these health care needs if we decide it's important. If we think it's something that's worth doing, then we can do it. We have solved tougher problems

than that. When the decision was made a couple of decades ago to go to the moon, a lot of people at the time said that couldn't be done.

Well, we spent the money and invested the know-how and so forth. And there were a series of remarkable trips to and from the moon. Americans landed on the moon safely and did various things and came back. That involved solving hundreds and literally tens of thousands of intricate, complex problems in order to make that whole thing happen.

The engineering and the thought and the creativity that's required to really come up with a workable health care scheme in this country is far less complicated. I think the challenge we all face—and I am speaking to myself as well as to you—is that we have to decide how important this is. Is this something we want? Where should it be on the list of national priorities? Should it be way down at the bottom, should it now even be on the list or should it be up near the top of the list, and has the time come to do something about it?

I will give you one other statistic to think about before I call on our professionals and that's this: we are finding that people today are living longer, and longer and that's a good thing although it's not an unmixed blessing. We are finding that better medicines and better health care and bett[illegible]et and a lot of other things are causing us to be able to live [illegible]nger. The profile of people in our country that are living into their 80's, into their 90's, and into their 100's is growing all the time.

We are going to find that these changes are going to bring with it others kinds of problems because not everyone is going to be in tip top shape that lives to be a 105 or 95 or 87 or whatever the age happens to be. But we can see this happening in the data that we collect about ourselves as a nation. So we ought to be able to be smart enough to look ahead and realize that if we now have a population that's living longer, more of the illnesses that tend to set in at senior age are going to be part of the picture. More and more people are going to encounter problems. Situations may develop where there is an enormous load from medical problems, from both the emotional and financial strains of illness. It seems to me that we have been spending our time on a lot of other problems, in many cases not as severe as this. We have to think about it in terms of how important we are to one another.

I am struck by this fact—and I will stop as soon as I make this comment. My wife Lori and I and our 2½-year-old daughter were in an airplane on the Detroit Metro runway in the plane right behind the plane that crashed two Sundays ago. We were waiting to take off on the runway right behind them. We didn't know that the plane had crashed until a little bit later when our plane didn't go and they finally took us back to the terminal. We were taken off the plane and a rumor was passing around that there had been a terrible crash that had just happened and that therefore the airport was closed.

The tragedy of that situation is one that I think we are all profoundly touched by because it happened in our State. You might have read about one of the Northwest employees who was on his way to work. He was coming around in that area and the plane

crash had happened and he went out to help and he was one of the people who found the little 4-year-old girl that was in that absolutely incredible wreckage.

I don't even know how she survived. It is truly a miracle. I came back the next morning and I walked that site and I saw what was there. It was the worst heartbreaking site you could possibly imagine. But that man went in with the others at some risk to himself to see if anyone was alive and they found that little girl.

Now, what's the point of my story? As a nation, when we come upon someone in desperate circumstances, we don't just walk on by. When we come by a crash scene on a highway, we don't just drive on by if there are people who need help, we stop and we get out and help. That's what people did at that crash site and that's how they happened to save that little girl's life.

The people who did that didn't know her and they could have stayed away for fear of the thing exploding and taking their lives but they stepped forward and they helped. The point is that we have been a nation that has not gone by accident scenes. We have stopped at accident scenes and we have helped each other and that's been a part of our nation's incredible history of performance and achievement, and is part of the kinds of values that we represent as a society.

We are connected to one another whether we know each other or not. We are connected to one another and care about each other and we're going to help each other. When one person goes down, instead of just going on by, we stop and help that person get back up. And we all know in the back of our minds that sometimes that might be us. If God favors us, and it never happens to us, we're the lucky ones. But it could be us or the person next door and whoever it is that person needs help, and we ought to help. We ought to view ourselves as connected.

And that's what a health insurance system is. If we're all laced into it, then everyone is protected. Everybody pays something but not everyone needs the benefit. Then you have a kind of protection for the whole society where nobody is fed into the meat grinder, willy-nilly based on where the accident happens or the illness strikes.

So one of the questions we must face is whether we are advanced enough as a nation to say we want to have that kind of system. There are a lot of different ways to do it. It doesn't mean we have to create a great huge Federal bureaucracy. It can be partly private, partly public. We can work it out any number of ways. The point is that we have to decide whether we want it. So the hearing today is designed not only to get the facts on the table so that we think about it together but so we can digest that information and decide what it is that we want to do and then see that it is done because we are a self government.

Thank you for letting me say that at this point. Gentlemen, let me start down through your panel and introduce who is here.

We have Mr. Donald Newman who is the president of Caring, Inc., which is a rural home health care agency in Ironwood which serves both Michigan and Wisconsin. Mr. Newman has been very active in home health care for many years and he will have some important insight for us.

Then, Mr. Don Drisham who is the assistant administrator for finance at the Marquette General Hospital. Marquette General is the largest hospital in the Upper Peninsula and is the only urban hospital. Mr. Grisham has been involved with the Marquette County Health Care Access Project and other health care initiatives in this area.

Mr. Wayne Hellerstedt is the executive director of Grand View Hospital in Ironwood, Michigan. Grand View is a small, rural hospital and has had some difficulty coping with the financial aspects of medicare's new DRG reimbursement system. He is going to tell us about some of the problems facing rural hospitals in trying to meet some of these human needs that we have heard about. Gentleman, we have a lot of other people that want to speak today too, so I am going to ask you to go right into your testimony. I would like you to summarize it as much as you can. Mr. Newman let us hear from you first.

STATEMENT OF DONALD NEWMAN, IRONWOOD, MI

Mr. NEWMAN. Senator Riegle, my name is Donald Newman. I am president of Caring, Inc., a rural proprietary home health care agency, and the Apothecary of Ironwood, Inc. The latter is a pharmacy which deals to a great extent with medicare and medicaid in its home care services of durable medical equipment, home IV, and parenteral and enteral nutrition.

Caring, Inc. is an active member of the National Association for Home Care and the Wisconsin Home Care Organization. However, the views expressed here do not necessarily reflect those of the organizations just previously mentioned.

I appreciate this opportunity to address the issue of catastrophic health insurance. To a large extent, the patients we serve are the elderly, who are in need of financial protection to guard against impoverishment in order to obtain necessary health care.

However, catastrophic coverage concerns admittedly are not only the concern of the elderly. There is a need to provide for some type of coverage for all individuals who cannot obtain access to the health care delivery system.

Though our agency has a policy utilizing a sliding scale concept, based on household income, all too frequently this assistance still makes care unaffordable. This is clearly illustrated when the parents of a young child with an inoperable brain tumor (neuroblastoma) had to decline services because of their inability to pay the sliding scale amount.

Similarly, a terminally ill and widowed patient with two teenage children had to decline our services because previously incurred medical bills left the family with no means to pay for the sliding amounts.

Today, however, I would like to focus on the catastrophic nature of chronic illness in the elderly. The fundamental health care needs of the elderly Americans is not coverage of costly catastrophic acute illness, but rather the coverage of the far more costly care needed for chronic conditions. Any serious catastrophic health insurance proposal must protect the elderly against the cost of long

term care and must include home health care as its first choice for provision of that care, when it is medically appropriate.

While working on a meaningful catastrophic long term care program, Congress should immediately take steps to remedy problems in the medicare home health benefit that are limiting access to home health care to the many medicare beneficiaries. According to a report by the Special Committee on Aging of 1986, recent policies of the Health Care Financing Administration "to restrain medicare beneficiary protection, combined with vague and confusing guidelines for providers, results in reduced access to home health care for the older Americans." The report also noted that although hospital discharges to home health have increased 37 percent since prospective payment for hospitals was implemented, the growth in home health care services since then has slowed.

A 1987 General Accounting Office (GAO) survey of hospital discharge planners revealed that 86 percent "reported problems with home care placements" for Medicare beneficiaries. Fifty-two percent of those surveyed cited "medicare program rules and regulations" as "the most important barrier" to these placements.

It is no coincidence, therefore, that HCFA's own statistics show that the percentage of home care claims denied under the medicare program rose from 1.2 percent in 1983 to over 6 percent in 1986. This figure does not include the many patients who are effectively denied medicare coverage because home health care agencies, incapable of assuming the cost of noncovered care, avoid claims submission.

This problem has not disappeared. Earlier this year, Congressman Staggers (D-WV) filed a lawsuit regarding the tremendous upsurge in medicare home health care denials. The American Association of Retired Persons (AARP) Public Policy Institute released a study last October that found "a recent and growing pattern of claims denials specifically aimed at the home health care benefit. This study was entitled "Home Health Benefits Under Medicare," also found a major problem in the great unpredictability in regional variations in denials made by the fiscal intermediaries. Having been recently assigned to a new intermediary, I know this first hand.

The current medicare home benefit is a limited one. The level of benefits available under medicare is often inadequate to care for the more acutely ill patients that are now being discharged from hospitals today. It only covers the acute services that are needed on an intermittent basis.

Take the case of a 70-year-old patient with terminal end-stage Chronic Obstructive Pulmonary Disease, requiring continuous use of oxygen, status post cancer with a colostomy, severe hypertension, and is essentially bedbound.

This patient needed to be discharged because the condition plateaued at a poor but unchanged level. Continued services of a home health aide and skilled nursing visits by a registered nurse every 2 to 3 weeks to monitor the patient's health status could possibly have prevented the repeated trips to the emergency room and costly readmissions to the hosptial that this patient has been experiencing. But once considered even temporarily stabilized, medicare

will not cover those services, and the beneficiaries can ill afford the expense on a self-pay basis.

The definition of what constitutes "intermittent care" varies tremendously, depending on the fiscal intermediary's interpretation. As a result, the national medicare program is not being enforced uniformly on what is being covered and what is not being covered. What is covered in one State is not covered in another.

A further restriction to home care for medicare beneficiaries is when a patient is receiving benefits from medicare, they cannot receive additional coverage from any other payment source. Such sources might be medicaid, private pay, self pay, insurance, etc.

For example, if a patient is receiving 3 hours of nursing care and 2 hours of nurse aide care three times a week paid for by medicare, and the patient and/or his family desires to pay for an additional 2 hours of nursing care the other 2 days, medicare intermediaries will deny the medicare coverage, claiming the patient is exceeding the "intermittent care". This either results in no care, limited care, or forced institutionalization of an individual whose family cannot sustain him at home, if medicare refuses to pay its fair share.

A patient's homebound status is also of concern to the beneficiaries and the providers alike. The current medicare homebound guidelines——

Senator RIEGLE. Let me just interrupt you. I want you to finish but I am going to have to ask you to summarize because we have about 40 people who have indicated that they want to speak from the audience and I want to be sure to get to them. I will put the whole statement into the record, but if you could go to the conclusion and that would really help us.

Mr. NEWMAN. Yes I will.

I believe the goals of any health care system must be to provide affordable and accessible health care with adequate reimbursement to the providers. This would insure adequate health care to all Americans.

I support the concept of catastrophic coverage and the availability of health care to all Americans alike, whether rich or poor, young or old. Let us learn from our past mistakes before making any catastrophic proposal into law. I sincerely urge Congess to provide for adequate and appropriate funding, rather than to curb costs by restricting beneficiary benefits through interpretive decisions. Yes; we need to eliminate the overuse and abuse. However, we must construct an adequately reimbursed system that provides affordable and assessable health care for all Americans alike and I thank you Senator.

Senator RIEGLE. Thank you. That's an excellent statement, it's very helpful to us.

[The prepared statement of Mr. Newman follows:]

CARING INCORPORATED

Administrative Office
200 East Ayer Street
Ironwood, Michigan 49938
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Testimony of

Mr. Donald W. Newman, President
Caring, Inc.
Ironwood, Michigan

Before the Senate Budget Committee

August 28, 1987

Sen. Riegle:

My name is Donald Newman. I am the President of Caring, Incorporated, a rural proprietary home health care agency, and The Apothecary of Ironwood, Inc. The latter is a pharmacy which deals to a great extent with Medicare and Medicaid in its home care services of durable medical equipment, home IV, and parenteral/enteral nutrition. Caring, Inc. is an active member of the National Association for Home Care and the Wisconsin Homecare Organization. However, the views expressed here do not necessarily reflect those of the above mentioned organizations.

I appreciate this opportunity to address the issue of catastrophic health insurance. To a large extent, the patients we serve are the elderly, who are in need of financial protection to guard against impoverishment in order to obtain necessary medical health care. However, catastrophic coverage concerns admittedly are not only a concern of the elderly. There is a need to provide for some type of coverage for all individuals who cannot obtain access to the health care delivery system. Though our agency has a policy utilizing a sliding scale concept, based on household income, all too frequently this assistance still makes care unaffordable. This

is clearly illustrated when the parents of a young child with an inoperable brain tumor (neuroblastoma) had to decline services because of their inability to pay the sliding scale amounts. Similarly, a terminally ill and widowed patient with two teenage children had to decline our services because previously incurred medical bills left the family with no means to pay for the sliding amounts. Today, I wish to focus on the catastrophic nature of chronic illness in the elderly. The fundamental health care needs of elderly Americans is not coverage of costly catastrophic acute illness, but rather the coverage of the far more costly care needed for chronic conditions. Any serious catastrophic health insurance proposal must protect the elderly against the cost of long term care and must include home health care as its first choice for provision of that care, when it is medically appropriate. While working on a meaningful catastrophic long term care program, Congress should immediately take steps to remedy problems in the Medicare home health benefit that are limiting access to home health care for many beneficiaries. According to a report by the Special Committee on Aging of 1986, recent policies of the Health Care

Financing Administration (HCFA) "to restrain beneficiary protection, combined with vague and confusing guidelines for providers, result in reduced access to home health care for older Americans." The report also noted that although hospital discharges to home health have increased 37%, since prospective payment for hospitals was implemented, the growth in home health care services since then has slowed. A 1987 General Accounting Office (GAO) survey of hospital discharge planners revealed that 86% "reported problems with home care placements" for Medicare beneficiaries. Fifty-two percent of those surveyed cited "Medicare program rules and regulations" as "the most important barrier" to these placements. It is no coincidence that HCFA's own statistics show that the percentage of home care claims denied under the Medicare program rose from 1.2% in 1983 to over 6% in 1986. This figure does not include the many patients who are effectively denied Medicare coverage because home health care agencies, incapable of assuming the cost of noncovered care, avoid claims submission.

This problem has not disappeared. Earlier this year, Congressman Staggers (D-WV) filed a lawsuit, regarding the tremendous upsurge in Medicare home

health care denials. The American Association of Retired Persons' (AARP) Public Policy Institute released a study last October that found " a recent and growing pattern of claims denials specifically aimed at the home health care benefit." This study, entitled "Home Health Benefits Under Medicare," also found "a major problem in the great unpredictability and regional variation in denials made by the fiscal intermediaries". Having been recently assigned to a new intermediary ourselves, I find this to be true. The current Medicare home health benefit is a limited one. The level of benefits available under Medicare is often inadequate to care for the more acutely ill patients that are being discharged from hospitals today. It covers only acute services that are needed on an intermittent basis. Take the case of a 70 year old patient with terminal end stage Chronic Obstructive Pulmonary Disease (COPD), requring continuous use of oxygen, status post cancer with a colostomy, severe hypertension, and is essentially bedbound. The patient needed to be discharged because the condition plateaued at a poor but unchanged level. Continued services of a home health aide and skilled nursing visits by a registered nurse every two or

three weeks to monitor the patient's health status could possibly have prevented the repeated trips to the emergency room and costly readmissions to the hospital that this patient experienced. But once considered even temporarily stabilized, Medicare will not cover these services, and the beneficiary can ill afford the expenses on a self-pay basis.

The definition of what constitutes "intermittent care" varies tremendously, depending on the fiscal intermediary's interpretation. As a result, the national Medicare program is not being enforced uniformly in what is covered. What is covered in one state is not covered in another. A further restriction to home care coverage for Medicare beneficiaries is when patients are receiving benefits from Medicare, they cannot receive additional coverage from any other payment source. Such sources may be Medicaid, private insurance, or self-pay, etc. For example, if a patient is receiving three hours of nursing care and two hours of aide care three days a week paid for by Medicare, and the patient and/or his family desires to pay for an additional two hours of nursing care the other two days, Medicare intermediaries will deny the Medicare coverage, claiming that the patient is exceeding the "intermediate care" requirement. This either

results in no care, limited care, or forced institutionalization of an individual whose family cannot sustain him at home, if Medicare refuses to pay its fair share.

A patient's homebound status is, also, of concern to beneficiaries and providers alike. The current Medicare homebound guidelines allow the patient to be considered homebound if he has infrequent or short duration absences from the home, primarily for medical treatment or "an occasional medical purpose." The current definition in the guidelines is interpreted in an inconsistent and varying manner by the various fiscal intermediaries. Recently, a claim for an 87 year old blind patient, needing the use of a walker for ambulation, was denied with reference to not being homebound because the patient could utilize the telephone and secure assistance from family members to leave the house. It would appear this individual is "essentially homebound" and leaves home only with extraordinary assistance.

Another area that will have an affect on accessibility to obtain health care by Medicare beneficiaries is the Health Care Financing Administration's recently published final rule to eliminate the return on equity capital for

all proprietary providers, other than hospitals and skilled nursing facilities, 52 Federal Register 21216, June 4, 1987. This rule became effective on July 6, 1987.

I urge Congress to take immediate action to rescind this regulation and retain the return on equity until a prospective payment system is implemented for home health agencies. Then, phase out the return on equity gradually as Congress did for hospitals. Such action is necessary in order to preserve access to home health care services for Medicare beneficiaries.

This abrupt and total elimination of return on equity capital would prompt many investor owned agencies to discontinue services to Medicare beneficiaries or drastically reduce the numbers they do serve. This would be detrimental to the home health community and to the beneficiaries, who benefit from the competitive mix of different providers.

Those proprietary agencies that elect to remain in the Medicare program will have a greater incentive to borrow in order to meet their needs, incurring interest costs that will be born by the Medicare program. These increased costs would reduce, if not outweigh, the cost savings

that HCFA projected for eliminating a return on equity capital to home health care agencies. To the extent that proprietary agencies continue to serve Medicare beneficiaries at less than cost, including the opportunity cost of capital, other payers will be forced to subsidize the Medicare program. The effect of which would be similar to imposing a tax on other payers to help support the losses created by the Medicare program.

I believe the goals of any health care delivery system must be to provide affordable and accessable health care with adequate reimbursement to providers. This would insure adequate health care to all Americans.

I support the concept of catastrophic coverage and the availability of health care to all Americans alike, whether rich or poor, young or old. Let us learn from our past mistakes before making a catastrophic proposal into law. I sincerely urge Congress to provide for adequate and appropriate funding, rather than to curb costs by restricting beneficiary benefits through interpretive decisions. Yes, we need to eliminate the over use and abuse. However, we must construct an adequately reimbursed system that provides affordable and accessible health care for all Americans alike.

Senator RIEGLE. Mr. Grisham.

STATEMENT OF DON GRISHAM, MARQUETTE, MI

Mr. GRISHAM. Senator Riegle, thank you for the opportunity to discuss current health care issues with you today.

As the regional medical center, Marquette General Hospital is the major health care provider in the Upper Peninsula of Michigan. Our mission is to provide a wide range of services to all the residents of upper Michigan. As we have heard today we offer these services regardless of the patient's economic status.

Catastrophic and long term illness many times is not only mutually distressing, but economically distressing to patients and their families as we have heard today. Medicare currently covers these issues inadequately, due to large deductibles, coinsurance, and noncovered benefits. Particularly distressing is the limited medicare coverage of long term illness, which often deletes and depletes a patient's financial resources.

The uninsured, and underinsured are other groups of people with similar problems. Over 900,000 Michigan citizens lack any type of public or private health coverage. This often results in the uninsured going without care or deferring their care until such times as their illnesses requires emergency services, adding both time and expense to their care.

Each year in Michigan, health care for the uninsured accounts for millions of dollars in documented expenses. Currently these expenses are borne by individuals paying directly for some or all of the health expenses, or by employers and or the purchasers of health coverage which absorb a portion of that expense through their premiums that they pay, or it is absorbed by providers who care for the uninsured and take a financial loss.

The uninsured are not a single, homogeneous population, but are comprised of various groups and there are different problems for rural and urban areas. For the person with little or no income, a publicly financed program are the largest source of health protection. Michigan has a good medicaid program, however, the gaps in the medicaid coverage leave many of the State's poorest people uninsured.

Again thank you for meeting and discussing these issues today and for the opportunity. Thank you.

Senator RIEGLE. Thank you very much. I am going to ask our last witness, as well, to summarize as much as possible. I am going to put your whole statement in the record. Wayne, it would be nice to hear from you now.

STATEMENT OF WAYNE HELLERSTEDT, IRONWOOD, MI

Mr. HELLERSTEDT. I will summarize as quickly as I may be able to.

We have heard a number of statements from individuals that have been severely harmed by the costs involved in their medical care. But one of the things I'd like to say is, it's not only costing the individuals, it's costing providers as well. One of our hospital's most basic commitments is to provide health care regardless of ability to pay and as a result in 1986 alone we provided almost half

a million dollars in care to individuals that could not pay for it. In addition, we have very many patients that are paying $5 a month or $10 a month because that's all they can afford to pay at the present time. And, one individual it will take in excess of 50 years to pay off their bill at the rate they are currently paying. So we know that that's not ever going to happen.

One of the things that concerns me the most and you alluded to it in your statement early on, is how the system is going to be paid for. The existing medicare program right now in my estimation is underfunded and very inequitably reimbursed in terms of how they are paying for services to the various hospitals. And I hope that when the various systems are being designed now are considered, that the equitability issue particularly for the rural provider is brought to a fore front. We in our particular organization right now, or as of 1986, discounted over $1.2 million to the medicare program. For us that means that we could have reduced our overall rates by 16 percent had the medicare program been paying its fair share of our costs, and that of course exacerbates the problem for catastrophic health care and the medically indigent. That hidden tax in essence get placed on these individuals as well.

Without going into all the details, I guess I'd like to say that as a hospital and as a provider we are concerned with these individuals and I compliment Congress and the various committees that are studying it and I hope that you can come up with something in the near future to be able to help not only the individuals but the providers because accessibility is going to become a problem for all Americans, particularly the rural Americans in the near future if something isn't done not only to provide for the individuals that are out there but also to provide a more equitable reimbursement system in general.

I know I have recently heard about a Senate bill, S. 1390 and at the present time, I know of no other bill that addresses all issues for the rural provider or rural acute care provider as well as that one does and I strongly urge your support for it.

Senator RIEGLE. Thank you, and I also want to again thank all of our witnesses for their participation.

[The prepared statement of Mr. Hellerstedt follows:]

SENATE BUDGET COMMITTEE

TESTIMONY OF

WAYNE HELLERSTEDT
EXECUTIVE DIRECTOR
GRAND VIEW HOSPITAL
IRONWOOD, MICHIGAN

AUGUST 28, 1987

My name is Wayne Hellerstedt. I'm the Executive Director of Grand View Hospital, a rural 72-bed, acute care hospital located in Ironwood, Michigan.

The issue of catastrophic health care and care of the medically indigent is an important one for all Americans. I'm sure that you have already heard many horror stories of individuals that have been bankrupt by illnesses and accidents that have cost them and their families tens of thousands of dollars. Let me tell you it not only costs individuals but health care providers as well. Grand View Hospital in 1986 alone charged off to uncollectible $355,000 which in our case amounts to 6 percent of our total operating budget. In addition, we wrote off an additional $120,000 to Hill-Burton, bringing the total amount of care provided to those that could not pay to over $475,000.

We are not alone in this. Most of the hospitals represented here and across the nation provide similar services. In addition to those accounts that are totally uncollectible, we have many individuals that are making regular monthly payments on their bills. Some pay as little as $5 per month because that is all they can afford. In fact, we have one patient that has a bill of over $6900. He is currently paying $10/month.

AT THAT RATE IT WILL TAKE HIM OVER 57 YEARS TO PAY UP HIS BILL IN FULL.

IT GOES WITHOUT SAYING THAT THERE IS A BIG GAP TO FILL WHEN IT COMES TO PAYING FOR BOTH CATASTROPHIC CARE AND THOSE THAT FALL BETWEEN THE GAP OF PRIVATE INSURANCE, HMO'S, MEDICAID AND MEDICARE.

AS THE ADMINISTRATOR OF A SMALL RURAL HOSPITAL, I HAVE ANOTHER CONCERN WITH REGARD TO THIS TYPE OF COVERAGE THAT FRANKLY FRIGHTENS ME. HOW IS THIS COVERAGE GOING TO BE PAID FOR?

I KNOW WHAT THE STATE AND FEDERAL GOVERNMENTS HAVE DONE TO RURAL PROVIDERS THROUGH THE MEDICARE AND MEDICAID PROGRAMS. THEY HAVE CREATED PROBLEMS THROUGH INADEQUATE FINDINGS AND INEQUITABLE DISTRIBUTION OF REIMBURSEMENT. I HOPE THAT THE FEDERAL GOVERNMENT DOES NOT DO THE SAME WITH THESE PROGRAMS. WE ALL KNOW THE BASIC QUESTION THAT NEEDS TO BE ANSWERED IS, "HOW CAN AFFORDABLE, ACCESSIBLE, QUALITY HEALTH CARE BE PROVIDED TO ALL PEOPLE IN THE UNITED STATES?" AT THE PRESENT TIME, MANY RURAL HOSPITALS ARE FIGHTING FOR THEIR VERY SURVIVAL. THE REASON ISN'T LACK OF PATIENTS OR POOR MANAGEMENT OR POOR PRODUCTIVITY. IT IS PLAIN AND SIMPLY AN INEQUITABLE REIMBURSEMENT SYSTEM. THE FEDERAL GOVERNMENT THROUGH THE MEDICARE PROGRAM HAS MADE MANY PROMISES THAT IT IS UNABLE TO FINANCIALLY KEEP. DON'T MAKE THOSE PROMISES IN A NEW SYSTEM AND THEN BALANCE YOUR BUDGET AT THE EXPENSE OF THE HOSPITALS IN THIS COUNTRY.

QUITE FRANKLY, RURAL HOSPITALS CANNOT TAKE MUCH MORE.

LET ME ILLUSTRATE WHAT I AM SAYING BY GIVING YOU SOME OF THE FACTS AS I KNOW THEM. FIRST SOME MICHIGAN FACTS. DID YOU KNOW THAT AS OF JANUARY 21, 1987, THE RANGE IN MICHIGAN'S MEDICARE PAYMENTS FOR A BASE 1 DRG RAN FROM APPROXIMATELY 2015-5527/DISCHARGE, APPROXIMATELY 2.75 TIMES AS MUCH IN THE HIGHEST REIMBURSED URBAN FACILITIES AS COMPARED TO THE LOWEST REIMBURSED RURAL FACILITIES. (SEE ATTACHMENT.) THE AVERAGE URBAN PRICE IN MICHIGAN WAS $3500 COMPARED TO THE AVERAGE RURAL PRICE OF $2500, OR A DIFFERENCE OF ABOUT 40 PERCENT.

DURING 1986, 60 PERCENT OF GRAND VIEW HOSPITAL'S PATIENTS WERE MEDICARE. DURING THE SAME PERIOD, WE DISCOUNTED 1.2 MILLION DOLLARS TO THE MEDICARE PROGRAM. IF THE MEDICARE PROGRAM HAD PAID THE SAME PRICE AS EVERYONE ELSE, WE COULD HAVE LOWERED OUR RATES BY 16 PERCENT. TO PUT IT ANOTHER WAY, THE FEDERAL GOVERNMENT HAD A HIDDEN TAX TO SUPPORT THE MEDICARE PROGRAM OF 16 PERCENT AT GRAND VIEW HOSPITAL. THAT HIDDEN TAX VARIES GREATLY THROUGHOUT THE NATION AND EVEN IN MICHIGAN. FURTHER, IT SHOULD BE QUITE OBVIOUS BY WHAT I POINTED OUT EARLIER THAT THE TAX IS BEING BORNE LARGELY BY THE RURAL CITIZENS OF THESE UNITED STATES. WE CANNOT AFFORD TO BEAR THESE TAXES - AND THAT'S WHAT THEY ARE - MUCH LONGER.

WE ARE TALKING ABOUT ACCESSIBILITY, ACCESSIBILITY FOR THOSE THAT

HAVE THE MISFORTUNE OF CATASTROHIC ILLNESS AND ACCESSIBILITY FOR THE MEDICALLY INDIGENT - THOSE THAT FALL THROUGH THE CRACKS OF PRIVATE INSURANCE AND MEDICAID. I'M HERE TO TELL YOU THAT ACCESSIBILITY WILL BE A PROBLEM FOR ALL RURAL AMERICANS IF THE PROGRAMS THAT ARE FINALLY PASSED TO SOLVE THESE PROBLEMS ARE NOT APPROPRIATELY FUNDED AND EQUITABLY REIMBURSED.

CONGRESS IS TO BE COMPLIMENTED ON THEIR CONCERN AND INSIGHT INTO THE PROBLEMS OF CATASTROPHIC HEALTH CARE AND THE MEDICALLY INDIGENT. WE AS PROVIDERS ARE VERY MUCH IN FAVOR OF SUCH PROGRAMS. THEY ARE NECESSARY. THERE ARE NO SIMPLE ANSWERS TO THE QUESTION OF AFFORDABLE ACCESSIBLE HEALTH CARE; HOWEVER, IN PLANNING FOR THE FUTURE, LET US LEARN FROM THE MISTAKES IN THE FUNDING OF EXISTING PROGRAMS BEFORE ACCESSIBLE HEALTH CARE IS A THING OF THE PAST FOR ALL OF US, ESPECIALLY THOSE OF US IN RURAL AMERICA.

I HAVE RECENTLY RECEIVED INFORMATION WITH REGARD TO SENATE BILL 1390. AT THE PRESENT TIME, I KNOW OF NO OTHER BILL THAT ADDRESSES THE ISSUES OF ACCESS TO HEALTH CARE FOR RURAL AMERICANS AS COMPREHENSIVELY. I STRONGLY URGE YOUR SUPPORT FOR THIS BILL. FROM WHAT I KNOW NOW AND WHAT I UNDERSTAND OF THE BILL, IT ADDRESSES MOST OF THE CURRENT INEQUITIES IN THE EXISTING MEDICARE SYSTEM.

INEQUITIES SUCH AS:

1. THE URBAN AND RURAL DIFFERENTIAL.

2. THE OFF SITE REVIEW BY PEER REVIEW ORGANIZATIONS.

3. ONE OF OUR MOST SERIOUS PROBLEMS RELATING TO PHYSICIAN RECRUITMENT AND RETENTION.

4. AND THE ISSUE OF SOLE COMMUNITY PROVIDER.

IT IS IMPERATIVE THAT SOMETHING BE DONE SOON TO RECTIFY THE RURAL SITUATION BEFORE IT BECOMES A CRISIS. SENATE BILL 1390 APPEARS TO BE THE BEST SOLUTION TO OUR SITUATION.

SENATOR RIEGLE, THANK YOU FOR YOUR TIME AND FOR ALLOWING ME TO TESTIFY BEFORE YOUR COMMITTEE TODAY.

Senator RIEGLE. I am going to indicate the order that we will follow now for the rest of today's session. When we begin with our witnesses from the audience who have asked to speak, we are going to go right on through until everybody that has asked is given the chance to speak. We have three individuals who have very serious time problems so we are going to hear from them first. So that everybody will understand how we will be proceeding, Mr. Fred Reynolds, Mr. Gary Wenberg, and then Mr. Ray Dube will be our first three, to be followed by Scott Matthews and then by Harry Scott. We will go on down in that order. Now, before we do that, we are going to do two other things. Let me indicate that there are rest rooms right across the hallway here for anybody who needs to use them and needs to know where they are. I want this to be the kind of meeting where people feel that they can go in and out as they need to and that we are not all required to stay where we are. We are now going to do two things to give everybody a chance to stretch their legs here. We have with us today from Hancock a group which is part of the Senior American Coalition and they are going to be giving us some views later on as we go down through our citizen witnesses. But they have been kind enough to offer to give us a little uplift today with a little musical uplift and we need that. As soon as they have done that and given us all a kind of emotional and spiritual boast I think we will then just take a momentary break here to allow our witnesses to leave, to allow the witnesses whose names I have just read to come on down and get seated at the table. We will allow anybody that needs to slip out of the room for a minute to do so. Then in very short order we'll start again so I would say unless you need to leave the room we probably ought to stay where we are so we can get right back at it.

Again, our next three witnesses will be Mr. Fred Reynolds, Mr. Gary Wenberg, Mr. Ray Dube, followed by Scott Matthews and Harry Scott.

And now, Toni Kracke, where is your group located here?

FROM THE AUDIENCE. Are you ready?

Senator RIEGLE. We are ready.

FROM THE AUDIENCE. We're going to sing it twice. We'll all stand up.

GROUP SONG. We welcome you Don Riegle, Don Riegle, Don Riegle, we're glad you came to listen and hear about our needs. There's health care insurance and formulas for funding. We welcome you Don Riegle to hear about our needs. We welcome you Don Riegle, Don Riegle, Don Riegle, we are glad you are here to listen and hear about our needs. There's health care insurance, and formulas of funding, we welcome you Don Riegle, to hear about our needs. [Applause.]

Senator RIEGLE. Thank you. We are now going to take a brief 3-minute recess. I want to again thank our panelists. We will have our next three ready to go and we will start right up again.

[Recess.]

Senator RIEGLE. We are about ready to start here. I think you will find as we go along that the things that we are going to be hearing from people who have asked to come and talk will be very striking. I have a list of about 50 people who have asked to speak. We are going to go right down through the list. I will ask you to

try to summarize as much as you can because I want to make that sure everybody gets to talk. In order to do that we will have to be a little mindful of the time. Mr. Reynolds, is he here? That's you. Mr. Wenberg, is Mr. Wenberg here? Mr. Ray Dube. That's Ray. We have somebody else who is going to have to leave from Calumet. Is it Reverend Langseth? So you will follow in that order. We may have gotten one shuffled out of order. We are going to move along here and everyone is going to get the chance to speak so bear with us.

Fred Reynolds we are pleased to hear from you now. I appreciate the fact that you are here and that you are going to testify now.

STATEMENT OF FRED REYNOLDS

Mr. REYNOLDS. Thank you, Senator Riegle.

Back in April my wife was taken to St. Frances Hospital in Escanaba when she had an operation. Two days later she had a heart attack and the next day she had a stroke. She is very bad right now.

I have been sending my bills right into medicare like they say—send them in as soon as you get them. Well that is wrong. You should never send them one at a time. You should get them all in one bundle and send them because I had the biggest mess you have ever seen. And if it hadn't been for Bonnie Miser and Betty Moore at the Gwinn Senior Citizen Center getting this thing straightened out and talking to Karl Numinen, I don't thank I would have lasted. But I am here.

But what I wanted to say is this. I was billed $850 by a doctor. Medicare, right away they approved $568.30. That's all he was supposed to have charged me. Then they paid 80 percent which they gave me $394.

Now the same billing of that doctor—he billed $100 for another doctor for consultation. But medicare refused that payment altogether. I was billed $1,168 by the physician that took care of my wife while she was in the hospital but medicare put down on my form that I billed them $1,476.85. I cannot find out where they got that figure. And we're talking about that.

So anyway, they broke it all down, and one bill was $26. Medicare approved $17.70. Another bill was $90.00. Medicare approved $83.80. She had 7 days visit in intensive care which was $280. Medicare approved $266. Now within 16 days a semiprivate was $560. Medicare only approved $283 of that. Well, they paid $35.00 on the intensive care bill but they only paid $17.70 on the semiprivate. I was billed $1,413—excuse me, I was billed $413 for an ambulance. Medicare approve $199.00. I got a $159.77. I was billed $220 for anesthesia. Medicare said $159.50. They paid me $127.60.

Then on down the line I was getting bills from EKG Associates and then I got my bill from the hospital. So I wrote the hospital and said I want an itemized statement of all things that transpired and all billing that you have paid or what you have billed me for. When I got the letter, EKG had been paid by the hospital. But here I had sent them the money so I sent them a letter and I want a refund of the money I sent to them becaue it don't belong to me it belongs to Blue Cross, it belongs to medicare.

And now like I said why—medicare should not pay the hospital bill until the patient has seen the billing to kind of give an OK on it, I think. And my doctor here in Marquette—by the way, she was in Marquette 63 days, we haven't gotten to that yet—but the doctor said that she would need a wheel chair for at least 12 months. And I went out to Wright and—out here out of town—I can't say the last name. But anyway they said medicare said you should rent that chair. I said "What?", and I said, "For 12 months?" and they said "Yes." "How much?" "$125 a month." So that's $1,500 for rent on a wheel chair which they are going to get back which is no fault of theirs. I fought medicare. I could have bought a new one for $450.

So I—it says on all the things I get from medicare, if you wish to have these bills reviewed OK let us know. But I got a statement from them that says we have paid you the full amount that you are going to receive. But if you want to still have a review stop into our social security office. So I seen these other people that had some great big statements here and terrible, terrible bills. Mine are not. Mine are minor. But just for a little stay in the hospital it's going to cost me over $2,000 out of my own pocket and that's pretty hard to pay out of $1,090 a month social security check. And I thank you for having me here and I hope that you can do something for the rest of all of us. Thank you.

Senator RIEGLE. Thank you Fred I really appreciate your coming and bringing that story to us.

Mr. REYNOLDS. Karl Numinen told me if I would get this all down—as I told him I was so nervous—that he would love to have it all and I got copies made so I going to leave with him all this information about what transpired.

Senator RIEGLE. Good. Thank you. We will follow through on it.

Mr. REYNOLDS. I have got to go home because my wife is home and she is in a wheel chair. Thank you all.

Senator RIEGLE. Thank you, Fred. You did a great job, nervous or not. You didn't seem nervous. Gary, we would be pleased to hear from you now.

STATEMENT OF GARY WENBERG

Mr. WENBERG. Thank you, Senator.

Senator RIEGLE. Could you pull that mike as close as you can so everyone can hear you?

Mr. WENBERG. Can you hear me now?

Mr. RIEGLE. I think they will as volume goes up.

Mr. WENBERG. I would like to address the need fo long term care beds or nursing home beds in the Upper Peninsul , and I will try to summarize this rather quickly. According to tl.e Michigan Department of Public Health Statistics, the 65 plus population in the Upper Peninsula has increased nearly 50 percent between 1970 and 1980. Today in 1987, the Upper Peninsula is approximately 15 percent of its population over 65 while the State has approximately 10 percent over 65. In some counties this figure approaches 18 to 20 percent. This means that as the 65 plus population increases some other portion of our population is decreasing. Thus the resources that are available for long-term care are limited or diminishing.

Since 1973, when I first encountered the problem of long term care beds in the Upper Peninsula the problem has not changed significantly. On any given day you may find 5 to 10 nursing home beds available to place patients in. And the waiting list may be 500 to 600 people long that are waiting for placement. The average occupancy of nursing homes in the Upper Peninsula over the last 5 years has been 99 percent which means no vacancy.

With the advent of DRG's, new phenomenon has began to show up in areas where utilization was high and that was patients where being placed into any bed that was available because the hospitals could not keep the patient for more than the average length of stay for that diagnostically related group. This means as Mr. Secor mentioned, that patients are being placed 100 miles from home, 200 miles from home and so forth.

The main limitation that we have deal with is the way nursing home beds are allocated in Michigan and that's utilization per 1,000 people 65 to 74 and 75 plus. In every area of the Upper Peninsula, I think except three these utilizations are already exceeded so there is no way you can build. And this is the main problem why there are problems placing the elderly in that type of care that is needed.

Senator RIEGLE. Thank you. That's very helpful for us to have and we are going to pursue that as well.

[The prepared statement of Mr. Wenberg follows:]

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THE NEED FOR LONG TERM CARE BEDS IN THE UPPER PENINSULA

According to Michigan Department of Public Health statistics the 65+ population in the UP has increased by nearly 50% between 1970 and 1980. Today in 1987 the UP has approximately 15% of its population over 65 while the State has 10% over 65. In some counties this figure approaches 18-20%. This means that as the 65+ population increases some other portion of our population is decreasing, thus the resources that are available for long term care are deminishing.

Since 1973 when I first encountered the problem of long term care beds for the Upper Peninsula the problem has not changed significantly. On any given day you may find 5 - 10 nursing home beds available to place patients in. The waiting lists and waiting times to place a person in a nursing home bed are long sometimes 500 to 600 people waited for placement in a long term care facility. In 1985 the last year the survey was done there were 583 people waiting for placement in a long term care facility. The average occuppancy of nursing homes in the UP over the last five years has been 99% which means no vacancy. With the advent of DRG's a new phenomenon began to show up in areas where utilization was high, and that was that patients were placed into any bed that was available because the hospitals could not keep the patient for more that the average length of stay for that diagnostically related group. In Houghton county 43 patients were placed out of the county because no bed was available for them within the county. In the first half of 1986 in a study over seen by the Western UP District Health Department 51 patients were referred out of the county by the hospitals because no beds were availale. In August of 1987 there are at least 50 patients waiting placement for a nursing home bed and the number reffered out of the county is not known at this time. This story can be repeated over many times especially in the Western Upper Peninsula where nursing home utilization is the highest and waiting lists the longest.

Although there have been replacement nursing home beds built, very few, if any new beds have been built since 1980. The present formula for the allocation of nursing home beds is regulated by the Michigan Department of Public Health. The present formula allocates beds based on utilization averages for different age groups. The 0-64 age group is allowed 201 days of care per 1,000 population, the 65-74 age group is allowed ~~1,085~~ 31,557 days of care per 1,000 population, the 75+ age group is allowed 30,213 days of care per 1,000 population. The average utilization rate for these age groups in the UP is exceeded in each case in 1985.

603/1,000, 4,929/1,000, and 38,5190/1,000. This means no county in the UP could build new beds, save Alger, Marquette Mackinac and they could build 42 new beds between them.

The fact is that the present formula for determing nursing home beds does not address any of these issues save the average utilization rate State wide for each age group. Unless the formula is changed to address rurality, chronic disease conditions of age groups, waiting lists, and those elderly patients being placed far from their residences and relatives, the formula will be the same in 1990 as it is now. The elderly and their relatives will continue to bear the hardship of a long term care formula based on averages and economics rather than the need for long term care.

The argument has been put forth that the patients are placed at the wrong level thus clogging the system and using up the bed space. In a letter received from Region I DSS in August of 1977 only six patients were refused payment because they were placed at the wrong level of care. In a study conducted by the Western UP District Health Department in the summer of 1986 fewer than 5% of the patients could have done better if placed at a lower level of care.

The argument for alternatives has been put forth, but unless those alternatives are available and the reimbursement for such alternatives is adequate, these alternatives are virtually non-existent. In most instances in the UP where an alternative such as home health care has been developed the utilization of the that level of care has little or no affect on nursing home bed utilization. Rather that level of care has experienced greater and greater utilization rates as time goes on.

The solution still seems to point to the fact that the present formula for nursing home beds must be changed to take into account rural areas and the special problems that exist there.

Senator RIEGLE. Let me acknowledge three individuals in the audience. We have among us Dr. Michael Coyne who is the former mayor and with Marquette Medical and Dental. We have Mr. Dave Anthony who is with Senator Levin's office and we are very pleased that he is here today. Also we have Sean O'Donald who is with Congressman Bob Davis's office. We are pleased that the three of them are joining us today. Mr. Dube.

STATEMENT OF RAY DUBE

Mr. DUBE. Mr. Riegle, I came here today in mostly—I am the administrator of Our Lady of Mercy Convalescent Home, and I would like to put the record straight. They say there is a lack of beds in the Upper Peninsula. The reason for the lack of beds is not because of the nursing homes. It is strictly because the State of Michigan with there certificate of need. They have not—I am in court right now with the State of Michigan. I am going to court with them to get a certificate of need which I have applied for and have not got at this time. I don't know if we are going to take them into Lansing or we're going to have it at Houghton County. But this is where we are at right now.

The bed shortage is strictly because the certificate of need at Michigan not because of the nursing homes won't build them. I thank you.

Senator RIEGLE. I see. It's important that you came to put that on record. Reverend, I sort of called you both at the same time. Who was the more extreme time problem?

STATEMENT OF REVEREND LANGSETH

Reverend LANGSETH. I am Pastor Robert Langseth of the Faith Lutheran Church in Calumet. I have 35 shut-ins in my medium-sized congregation and I bury 47 people a year—one every 9 days. I am well acquainted with elderly, with illness, with institutions and with people.

I am also chairman of the Senior American Coalition which in 1985 took testimony like this in four public hearings. We have 6 hours of record of the people's needs as long term care is essential. It is available to you along with the 13 minute summary.

My presentation today will be brief and crisp I trust. The national statistics show that the health care has improved in the Upper Peninsula and in America during the last years after the Hill-Burton funds after the medicare program. We went on the road toward a availability of health care for all people regardless of cost. We commended that to you, we commend the Congress for that.

Beginning in 1980 there has also been a counter revolution with cost containment that has been devastating to the rural hospitals, to the staffs of the nursing and doctors and to the health care industry and to the private individuals themselves. When the hospital has to write off the kind of money that we heard about, that's just one hospital of many. When the nursing staff has to leave because the hospitals close and the DRG's require the transfer out, the moral of our health care people is rapidly disintegrating. You ought to know that. I speak as an advocate for them.

I encourage you therefore to join the Rural Health Care Coalition in Congress if you are not already so because our rural hospitals are at a crisis point. I am a part time chaplain at a radar site. We have medical aid station. Unless something is done for the rural hospitals, our rural hospitals will become Medical Aid Stations, Marquette will become the center and heart attacks will not last for a 140 miles trip to Marquette. I commend you for the work.

Second, our critique is that first things are not being kept first. Good management of resources is stewardship but stinginess on the part of the national economy is not the same as stewardship. The good Samaritan story said that resources of finances comes second as resources of people, and Jesus said go and do likewise.

Our learnings as a pastor and as a coalition from working with elderly people is that our present programs of the funding processes develop a five-stage DRG death. This is installment dying that we can document.

We send our people 120 to 160 miles away. The first stage is depression, isolation. The people feel that they are abandoned by their doctors, by their mate, by their friends, by their clergy and by God. Depression is stage one.

It goes on to incoherency, stage two. The people who are apart from all that they know become disoriented. They believe that their clothes are sold in garages sales. They believe their house has been removed from their family setting. They become disoriented and there is no familiar voice to call them back to reality. Disorientation and incoherency, stage two.

Stage three, on the descending order: the increased physical illness. They now develop new pains, new illnesses, new fevers because of the tenseness and tension within in their bodies and beings. The nursing homes do not get paid for the skilled care now required or if they have to be shipped back to acute coverage and as a result these people are not properly cared for.

The fourth stage is the loss of the will to live. If I can't get home any other way, if there is no one to take care of me close at hand that I know, then I refuse to live.

And stage five is that death fulfills their wish and they are brought back in a hearse, brought back to their family, their community and their people.

That is the stage that present health care policies develop within our people and to which we object. And for your interest in health care today and for this hearing, we've got one word: Yippy! [Applause.]

Senator RIEGLE. Thank you. That's a very powerful statement. That's why I think it's so important that this hearing takes place here in the Upper Peninsula. I think the problem here is different. That's one of the things we are hearing today. The distances, the ability to have facilities where people can get at them and have their needs treated properly is a problem that is different here and I am sure that this is true in other rural areas of the State where there are more miles between towns and facilities.

But we can do something about changing this, and that's what this hearing is really about today. The hearing is to gather the facts and to gather our strength to do something about the facts. I can give you assurances in terms of my role. I spent 11 years strug-

gling to get on the Senate Finance Committee so that we would be in a position to deal directly with these issues because we have not had our State represented on that committee for a long length of time. Well, we are now there. And because I am there you are there, we are there together. So we are going to have something to say about it and we are going to fight to get something done in this area. I can assure you that.

Mr. Scott, you were very patient and I appreciate it. We would love to hear from you now.

STATEMENT OF HARRY SCOTT

Mr. SCOTT. Senator Riegle, I am pleased that you chose to make a few remarks between those of mine and one of God's messengers. I can't possibly follow him.

I am here on the part of the Michigan County Medical Care Facilities Council. That is a council of Nursing Home Administrators, County Nursing Home administrators throughout the State.

Senator RIEGLE. You need to speak right into that mike. Maybe we can increase the volume a little bit, too.

Mr. SCOTT. One of the fall-outs of the DRG program that has not been mentioned today is the phenomenon called bed holding. Bed holding occurs when a patient from a nursing home has to go to the hospital for care. The need for nursing home beds in the Upper Peninsula is so critical that many of our patients are afraid if they go to the hospital they will not have a bed and a nursing home to return to.

We as Nursing Homes Administrators are paid a limited amount to take care of our patients and cannot afford the loss of revenue to hold those beds. Hospitals are put under such crunch that some hospitals will pay to hold that bed, for it is cheaper for them to place a patient in a nursing home than it is to house them in the hospital during convalescence.

In the State of Michigan we did have, and the Federal Government did have, a bed holding policy prior to November 15, 1980 at which time it was terminated. The council asked me to read into the record a resolve and it's very short, and I would beg your indulgence to do so:

> Whereas the Michigan Public Health Code allows a nursing home to hold a bed for up to 10 days during the patient's temporarily absence for emergency medical treatment provided the nursing home receives payment for the period of absence;
>
> And whereas prior to November 15, 1980, funds were appropriated and available to hold a title 19 medicaid patient's bed for such absences for up to 10 days;
>
> And whereas such funding is no longer available and the matter is one of concern for Michigan County Medical Care Facilities Council because of the resulting hardships;
>
> And whereas these hardships effect the health of the patient, place a burden upon the family, place demands upon their pocket book and oft times result in patients being forced out of the medical care facility with no actual possibility of return to their community.
>
> Therefore be it resolved that we urge the Governor, the Department of Social Services, the Medical Service Administration to appropriate sufficient funding to allow payment for the holding of a bed as permitted by the Michigan Public Health code.

I have a few other issues that I would like to address and I will summerize those. Senator Riegle, we wish to applaud the efforts of the Federal Government to establish catastrophic illness insurance.

We realize that it needs a cap. We are very concerned and urge you to cap based upon income rather than age requirements.

The second issue I would like to address is the need for long term care insurance. Very few patients who have had long nursing care insurance policies which cover more than the medicare deductibles and coinsurance fill-ins. Due to increased restrictions imposed upon covering a patient for care by medicare, medicare has become almost non-existent. This has, of course been a land slide profit for private insurance companies who sell long term medicare fill-in policies. But when medicare doesn't pay most policies for fill-in coverage do not pay either. There are a few good insurance policies available on the market which cover long term care after medicare. But so limited is medicare payment in skilled nursing care facilities that most patients are denied coverage upon admission. Based upon medical determinations according to medicare rules that the older person does not find out they have no coverage until it's too late. Because they believe that medicare will provide the services they do not purchase private insurance. People do not understand that medicare offers little or no long term coverage. Therefore, we feel an education program is needed, maybe even more than law.

The next issue I would like to cover—there are many programs available to persons to restrict them from having to come into nursing homes and that restrictive environment. There is home health care, meals on wheels, hospice and now there is a trend toward respite care. Alzheimer's patients—there is no less than at least four bills currently before the Michigan legislature on Alzheimer's, demanding research, demanding the Public Health Department to collect data from physicians, the physicians provide the data to the health department, and finally setting a deadline for the health department to issue and publish a report on Alzheimer's.

Day care programs for the elderly in the State of Michigan in county nursing homes could be accomplished. If we could eliminate from medicare such techniques as dumping of costs in what is termed as nonreimbursable cost centers, we could help with Alzheimer's patients, we could help relieve those families by providing day care if we had some way to be reimbursed for that care.

The last issue I wish to address and I know I am getting rather wordy——

Senator RIEGLE. But this is excellent testimony and every point you've made I think is important so take the time you need.

Mr. SCOTT. The last issue I wish to address is that of dental care in the elderly. The medicaid program does not provide for pulling of teeth, it does not provide for filling of teeth. It does provide for some slight prophalaxis.

A person with a few occluding teeth certainly does not have the means to masticate his food properly. But, the final determination is made upon whether or not a person can eat—we can all eat, but is that eating if you have just a few occluding teeth? I have a mouth full of teeth and they are a little sensitive and I still don't want to eat sometimes. Are we to chose for our elderly people again? Can't we provide them with some funds to provide them with dental care. They do care. What about appearance. We can't just assume that old people don't want to look good, and I wish to

share and possibly this will lighten up this heavy testimony a very cute incident that happened at the Marquette County Medical Facility.

We had this very proud Upper Peninsula lady who was a lady of means in her community as her personal records would verify. She was admitted to the nursing home and upon being informed one day that the dentist was there and wished to see her she dressed as best she could, with the help of an aide was placed in a wheel chair and was carried to the dental clinic. They placed here in the dental chair and the dentist asked her to open her mouth she opened her mouth and he saw what he thought was the most ill fitting set of dentures he had ever seen. Upon further examination he found that she had taken her roommates teeth and gone for the dental appointment. [Laughter.]

Senator RIEGLE. Did she give them back?

Mr. SCOTT. We did. Thank you for allowing me to speak. [Applause.]

Senator RIEGLE. Before we hear from Karlyn, and then from Dr. Coyne, I am going to ask for a show of hands on a couple of things here. I am going to put a couple of questions to the audience. I want to know how many of you feel—I am going to ask for those who are in favor and those who are not in favor or want to think about it—I would like to know how many of you feel that we definitely should move ahead now with some catastrophic health insurance measure to extend medicare to cover the gaps on the hospitalization for severe illnesses that take you to the hospital, to put a dollar cap on those expenses. This is the problem that the President and the Congress are focusing on. How many of you think that, at least as one first step, that it's very important to move on that now and would like to see that done this year? Can I see the hands?

[The audience complies.]

Senator RIEGLE. A very substantial majority. How many of you here have reservations about that or don't think the government ought to do it or want to think about it more? Anybody on the other side of this issue? Apparently not. Let me ask this question. How many of you feel that it's time to go beyond that, that we need to establish by whatever means—obviously it's got to be worked out and there will be different ideas and so forth—but how many of you feel the time has come for a broad health insurance coverage for senior citizens in this country and citizens of other ages, so that when illnesses or accidents strike, creating massive bills, that an insurance system that includes everybody be in place. This would spread the risk and would provide the wherewithal to meet those needs when those terrible occasions happen. How many of you think that the time has come to do something like that in this country? May I see those hands?

[Audience complies.]

Senator RIEGLE. In response to an inaudible question from the audience. Some form of a national insurance system. Bow, there may be some partnership between the government and the private sector. I don't know quite how it would be structured. But the point is, if it's our judgment that we need it, we will work to figure out the best way to do it. I would like to know how many of you would

have serious reservations about that and would feel that that is not a step that we should take on a national basis, that we should not try to work everybody into a common insurance system.

[Audience complies.]

Senator RIEGLE. I see one hand. If you feel that way put your hand up because we need to get an expression. There's one other here. There are at least a couple in the room. But overwhelmingly the sentiment in this room at least is on the side of moving ahead to craft some kind of system that can put an honest-to-goodness safety net underneath these extraordinary health care bills for people whether they happen to be seniors or whether they happen to be children or whether they happen to be people of ages in between. I think that's a clear sentiment in the room. [Applause.]

Let me say this to you those of you who feel that way—I want it to be clearly understood this is not a partisan comment, we are going to have a Presidential election in the country next year and we are going to get a new President, because our current President can't run again. There is an active competition going on in both parties as you well know.

I would like to urge you that when the political candidates for president come into our state from either party and you have the chance to talk to them and interact with them and give them your 2-cents worth, I think it's very important that they hear an expression of this feeling. Let's get the issue of national health care needs into the presidential debates and see what ideas each one has. Let's see where they stand, let's see who can come up with some ideas as to how best to do it so that it is an efficient system. Obviously, if it's going to be a system that creates a huge bureaucracy that focuses its efforts not to pay bills like Mr. Scott just defined, that would not be a very good system. So we want a system that not only has the right stated purpose but the one that is going to work, and is going to be cost effective and efficient, and one we can be proud to have, not one that makes us feel like we are criminals if we have to get help when a need arises.

So I would urge all of you that feel strongly about this to make these candidates talk about it in a constructive way. When you go to meetings where these candidates come or their workers come, ask where they stand on these issues. Indicate you want to see their position papers. If you get a chance to ask a question when a presidential candidate is here, ask questions in this area. What is their view? How do they feel about it? How serious is the problem? What national priority would they assign to it. Because this presidential election is your election. It's to elect our President, whoever that happens to turn out to be. And I think you can help force this issue onto the national agenda. I just make that point to you. If you feel strongly about it, that is a way to cause something more to happen about in addition to what I and others in the Congress intend to do who feel strongly about it.

Next we will hear from Karlyn Rapport who is at the table. Then from Dr. Coyne. Is he here? Yes; would you please come down and be seated. Then Mr. Alan Labreche. Do you want to come on down and be seated, Alan? Then Mr. John Eickhorst. Is John here? Yes; John do you want to come down. Maybe we are running out of

seats. You will be followed by Travis Martin. Karlyn we would be pleased to hear from you.

STATEMENT OF KARLYN RAPPORT

Ms. RAPPORT. Senator Riegle, my name is Karlyn Rapport. I am a speech and language pathologist. Victims of traumatic brain injury predominate my case load but I also work with patients who have had cancer, stroke, Alzheimer's disease.

My patients frequently require supervision because their brain injury renders them impulsive, confused, lacking in judgment, attention or memory.

My major concern is accessibility and insurance coverage for a continuum of care that is needed by victims of a catastrophic illness. Recent legislative efforts appear to be geared towards the aging population but this does not answer the needs of younger citizens who need care.

While a patient's insurance may cover his hospitalization and perhaps 60 days of out-patient care they are not covered for transitional care, for community re-entry programs which make the difference between institutionalization and a return to home, between placement in a sheltered workshop or employability. Respite care for those individuals in the home, part-time in-home care, overnight care, are the most urgently needed. But 24-hour respite care and paid-for companions, reimbursable placement in dementia units in nursing homes, are also needed to be part of that continuum of care required by victims of Alzheimer's and traumatic brain injury.

We are playing a very cruel game with these shattered families. If this patient is a child of a care giver the families can obtain chore service for respite care. But a wife is not entitled to obtain this respite for her husband's care. An elderly patient without family and friends to provide care for him will receive a higher benefit then those equally disabled but receiving care from a family member. The family care giver is not accorded any recognition or compensation. And although the major thrust of government is for community care and policies to avoid government expenses providing institutional care, the care giver has very few options.

They are sleepless, or their sleep is interrupted because they fear that their loved one will wake up confused and hurt himself. Care givers need to be on the alert 24 hours a day because they don't know when an impulsive act could mean an injury. The grief over the loss of that family member as he once was, the anguish when professionals say your family member could be helped if he were placed in an intensive residential facility that would provide the care he needs, but your insurance does not cover this.

Add to this, financial burden. There is a loss of wages of the bread winner. The spouse, especially the wife is unable to work because she must provide the care and the supervision that that family member needs. SSI is not sufficient to live on. Medicaid requires a spend down which results in the family and the spousal impoverishment.

The stresses are enough for many wives to say to me "I don't know how long I can take it". Many decide on divorce. Others become ill themselves, either emotionally or physically. And what is the fate of the patient then? Forced or inappropriate institutionalization.

Legislation which addresses the problems of catastrophic illness must address reimbursement and respite care, coverage for long term care, and separation of jointly owned assets in half to determine medicaid eligibility. Compensation for the impoverished care giver commensurate with that paid for others who provide comparable care. These families are shattered by catastrophic illnesses. They are angry at agencies which do not offer help and the support they need. And it is a system which is inhumane and unjust.

I appreciate the opportunity to speak to you and I really appreciate your having this hearing. It is a breath of fresh air when we feel like we have been spitting in the wind for so long. Thank you.

Senator RIEGLE. Thank you Karlyn. [Applause.] Dr. Coyne.

STATEMENT OF MICHAEL COYNE

Dr. COYNE. My name is Michael Coyne and I am a physician. I am also the mayor pro temp of Marquette, and I also work with Karlyn Rapport. It's a pleasure to be sitting on this side of the podium at a public hearing so I rather relish this role.

My specialty in medicine is physical medicine and rehabilitation. It primarily deals with individuals who have catastrophic illness. Each year the rehabilitation unit where I work serves about 400 people who suffer catastrophic illness. These people vary in age from newborns to people in their 90's. Their bills range from $12,000 to literally millions of dollars for their life time. Not only is their physical ability altered by the catastrophic illness but their whole life is effected.

I am here to specifically state as an individual and as a physician the need for a catastrophic health insurance across the board. It is not something limited to the elderly.

In Michigan we have I think an example in place of an excellent insurance coverage—Michigan No-fault. We have created in the rehabilitation unit two classes of individuals. People who are covered by Michigan No-fault have every single expense for their entire life paid for if it is a result of an automobile accident. That leaves about 200 people who have basically inadequate health care coverage for their catastrophic illness each year that we have to deal with. I think you have heard examples of three patients today who have spoken of the tremendous both financial burden and personal burden that is place upon them and Karlyn, I think gave a good example for just one simple diagnosis. I could give you 300 hundred testimonies of each year of this recurring frustration that individuals have.

I would urge you and your colleagues to pass this bill. I would urge to eventually, as a second step, cover all ages and I would also urge for it to be expanded to cover the chronically ill. I call on your colleagues in the Senate and the House particularly to reexamine their priorities by listening to the testimony of the people that they represent and also to call on them. Some day they are going to

have a catastrophic illness occur in their family. I would hope that they would particularly think about that in establishing the national priorities. Think about that when they want to spend trillions of dollars on a national defense program as opposed to listening to a gentlemen talk about his wife and his frustrations and all the other stories. It's going to happen to them someday.

I also would like to join Karyln in thanking you for your interest and in particular for your commitment. Thank you.

Senator RIEGLE. Thank you. You are kind to say that. [Applause.] Let me let the next group know who will be up so that they can get ready. Toni Kracke, Lydia Maki, and Pastor Aden, in that order. Alan, we would like to hear from you now.

STATEMENT OF ALAN LABRECHE

Mr. LABRECHE. Thank you, Senator Riegle. I guess I am speaking on my own behalf, but for people who don't realize what's going to happen if they come into my situation. I am on a long term disability. This means that suddenly I left work and this was in December 1985. My income went from going to work everyday and drawing my income and my budget to two-thirds of what I was normally getting.

OK, when I left work my insurance left along with me but I could stay on a self-pay basis. When I was working my insurance was $14.37 a pay period which was biweekly. Now it has gone to $287.40 which is one-fourth of what I receive for two pay periods. So my concern is that I cannot go to another insurance at a cheaper rate because my situation would not be covered for the first 2 years. I feel locked into the insurance that I had at work on a group basis but now as a copay I am paying 10 times more than I was working and receiving one third less income. I still have a 13 year old son at home. So this is a kind of a drain and I feel that we should have some type of national insurance to cover this situation, not just for myself. I feel that I have a very minor problem here. But people coming along that are going to run into this—we do not look at this when we are budgeting—what we can spend on buying a house a care or anything else. And when this happens then we have to either drop our insurance or pay a high premium which puts us in awful bind. So I hope you can do something on a national insurance basis. Thank you, sir.

Senator RIEGLE. Thank you. That's excellent testimony and we appreciate having it. [Applause.] John Eickhorst.

STATEMENT OF JOHN EICKHORST

Mr. EICKHORST. Thank you, Senator Riegle. My name is John Eickhorst and I work at Propylon the place that Dr. Boyd spoke of earlier. I am real proud to work there and be associated with Propylon.

One of the very best things about Propylon is that for many of the people who live there the alternative would be a nursing home. And it's just my opinion that the only people that belong in a nursing home are those that don't know that they are there or willingly want to be there. If they can be at home and be as well, you know, do as well, that's where they should be. The problem with this is a

need for people that would be in a nursing home that are sick or have some permanent chronic disability and need attendant care. And this is expensive.

The people fall into two categories. They are either—they've gotten to the point where they are poor and they are on medicare. So they have a choice they can either be in Propylon or some other facility like it of which there are very few, or a nursing home. The other group of people are those who do have enough income. They have an ability to pay for caregivers themselves. What happens is they in effect become one of the poor people because they spent all there money on caregivers.

So those who depend upon the Department of Social Services, those people who are on medicare, they are dependent and that's the rub. I don't know any way except to explain that this is inadequate. There should be a national entitlement for people who need home health care. And there is two reasons for that. One is humanitarian; it's better than being in a nursing home. The other is financial and it's simple dollars and cents. It's cheaper to have them at home than in a nursing home.

There needs to be an entitlement because otherwise I don't know any other way to do this but to say that they have no choice but to be under the auspices of the Department of Social Services which is being under their thumb. The degree of humanity with which they administer an exception program, which is anything over $333 a month, the degree of humanity there is zero. They have absolutely no interest in doing this. And I don't think—and the only thing I can say in defense of Michigan Department of Social Services is that I don't think they have a conscious effort—it's not a conscious effort to make this thing become expensive at the cost of medicare and medicaid but that is essentially what happens. They don't get enough money for enough care hours. The people get sick. They go to the hospital. They are there for a long time and it's ridiculous. And you know, just as a taxpayer, if I were to see this going on it would make me really angry.

And the difference of what it takes between being sick and being well and being taken care of adequately is just insignificant compared to the hospital expenses and, you know, the expense of their health as well. Therefore I have to urge that some sort of national entitlement be established for people—anybody except those so well off that they could afford not to become poor being sick, you know, they can pay for this kind of help. It doesn't make any sense to do anything else. Thank you.

Senator RIEGLE. Thank you very much. Travis.

STATEMENT OF TRAVIS MARTIN

Mr. MARTIN. Thank you, Senator. I will try and make my remarks very brief. I wrote a four page letter to your office and I got a very nice response and I was asked to talk about these three areas.

When we talk about catastrophic health insurance and we talk about the long-term hospitalization and the DRG's, something gets lost in the shuffle. And that is that the mental health of the people that we treat, and that if we provide more monies for outpatient

mental health services that a lot of the catastrophic illnesses could be avoided.

A Medicaid patient gets $500 per calendar year for mental health services. At the prices even in the community mental health service centers that's five to six sessions per calendar year. That is not enough to deal with long term depression or long term illnesses of any kind.

The other significant process in that is that they don't get a chance to choose who they go to for care, especially in welfare clients. It states basically that they must go to a medical facility here in Marquette County which provides excellent care or a PhD. Yet the State qualifies MSW's, limited license psychologists etc. as all qualified to provide quality care and yet these people can't choose to go.

Mental health clinics have waiting lists. It is not by a choice of there's but they can only provide so many services in a day. Yet those people who are put on long waiting lists, end up not showing up for services, ending up in the hospitals which cost triple the amount had they been able to be seen in a mental health practice.

One of the things that I would like to see if a person is qualified by the State to give care, then the people whether they be welfare clients, medicaid clients be allowed to choose to receive quality care from quality people.

The other thing is the number of red tape issues that people have to deal with. For example, I deal with Vietnam Veterans. By government law, I can't advertise that I have the contract. There is a question; how is the veteran supposed to know where to receive the service if the person can't tell them that the service exists? And this is government law, not State law.

And I am looking at the betterment of quality care which also has to do with training. In the Upper Peninsula, there are not lots of minorities but I think that when people are trained to deal with health care situations that they should also be taught to deal with what those minority issues could be in dealing with those issues. And that's all I have to say. Thank you. [Applause.]

Senator RIEGLE. Thank you very much. Toni.

STATEMENT OF TONI KRACKE

Ms. KRACKE. As you heard in our little song we do indeed appreciate having you here and giving us a chance to speak about the health care needs we experience in the Upper Peninsula.

I ask for your indulgence in that the buses must leave after our three people speak and the people will be exiting to the left as they leave this room.

You're concerned about catastrophic health insurance. This would almost likely cover organ transplants right? Well, we are asking you to think about the transplant of entire human beings to a place far from their home, loved ones and support from family, clergy and friends. This happens too often in the Upper Peninsula, when the time comes for some of our weakest and most frail members of society to need a nursing home bed. Truly, the heartbreak involved in such a situation needs to be addressed.

We are to be judged as a society by the way we treat our weakest members. What a terrible judgment it is for us to be sending people away from their homes because we are prevented by a quota system and by funding mechanisms from allowing them to receive the needed care here where they live.

I read to you from yesterday's Daily Mining Gazette, our local newspaper one paragraph. "These are issues of importance for the Keweenaw Peninsula, mainly because so many of our residents are elderly. In some communities in the copper country senior citizens make up nearly 25 percent of the population and in terms of catastrophic events nothing is more devastating financially as well as emotionally as placement in a nursing home. And our people go there as a last resort. They don't seek to be there."

We have a small group, people prepared to speak on specifics related to health care because we didn't want to waste your time with many, many people. We also have a silent majority who are here giving us their support merely by their presence.

We call on you to act on behalf of all the voters and taxpayers of the Upper Peninsula to address this issue from the Federal perspective, to make your findings known from these hearings and our needs known to appropriate State agencies like the State Health Care Coordinating Council. They are the ones who determine the quotas. The Health Department. They did a lengthy and comprehensive study that documents the need and they are to be commended there. The Office of Services to the Aging, the Michigan Legislature who does the funding, and anyone else who will have some impact on this need.

We have a packet to present to you that gives support and documentation to what you will hear today and we could have had more people speak but it wouldn't be necessary. You have heard it all. Thank you very much for being here. [Applause.]

Senator RIEGLE. Thank you very much, Toni. Lydia, before we hear from you, this issue has risen several times now today already about the lack of nursing homes in the communities where people live. There is just no excuse for that. I don't care what the arguments or the reasons are. The fact is that we need them where they need to be and we need to change the laws if the laws are standing in the way. I appreciate everything that you are saying because we are educating one another here with this kind of discussion and this is, in my view, the way government ought to work. There ought to be the chance for us to pass things back and forth and figure out where we are and where we need to go. But there is absolutely no reason why we can't construct in communities of some reasonable size, a nursing home capability where people can be in there own communities. We've got people out of work in the Upper Peninsula that know how to build things and how to put things together and if we don't have nursing homes where they're needed then we ought to get them built where they are needed. The notion that people are being moved hundreds of miles away from their community and their loved ones, as the reverend said earlier, is a death sentence to go off somewhere where they are not going to be able to function. That's outrageous on its face and we don't have to accept that. That is not the way America is supposed to work. This is our government not somebody else's. We elect the

government and we are the government. So if the decision is that we want to have nursing home capability and resources in our community, we can have it. We all pay big tax bills today. We pay big local tax bills, we pay big State tax bills and we pay big Federal tax bills and these are our dollars. If you want the dollars spent for those kinds of services then we can have it. The same is true with education and with day care and other things that are important today. You don't have to accept things the way they are. We are here today as a clear expression of the fact that there are some things that need to change.

But the idea that we can't find our way to a solution to this nursing home thing is just wrong. We can. I will tell you, you have stealed my determination to do it because it has to be done. I see the requests that come in for spending money at the Federal level—I mentioned Star Wars at a trillion dollars, one thousand billion dollars for one program. We've got all these nuclear warheads stacked up right now. That's just one area where we spend money and we dare never use them. We've got them all but if one goes off, followed by another, and another, everybody basically disappears off the planet.

The notion that we've got tens of billions of dollars for that but we don't have a few thousand dollars to build nursing home facilities where they are needed just stands the truth on its head. We don't have to accept that kind of nonsense and we shouldn't accept it, and I am not going to accept it. If you are unwilling to accept it, and there is a general feeling about that we can do something about it. When the elected officials come whether they are from the State or the Federal level track them down and speak to them about this and tell them you want it changed and if it's not changed they are going to be changed. That's what elections are about. If they don't get the message, elect somebody that will get the message. Lydia.

STATEMENT OF LYDIA MAKI

Ms. MAKI. Senator Riegle, I am Lydia Maki from Kenton.

My husband gave the best years of his life working for the government. He worked for the U.S. Forest Services for over 30 years. Now he is an Alzheimers patient. He is almost blind from diabetes and had four bypass surgery and he is paralyzed on his left side all the way—his arm and his leg and he has to be in a reclining position constantly.

He is getting bed sores and they—and he is in a Wisconsin nursing home and I live in Michigan. And I am having a hard time getting medicare and Blue Cross, which I pay $225 every month is taken out of our Blue Cross insurance. And I do not get hardly anything from Blue Cross back for his pharmacy bill which are tremendous because he needs so much medication plus diabetic medicine.

I pay $20,000 every year for his care at the nursing home and I have to travel 115 miles to see him. I wish he could live in a Michigan nursing home. It would be closer for me to visit him.

I also have had cancer, skin cancer, and two—I don't know what it was I had. I have had operations and I would like some chore

service like my neighbor next door to me who has both of his legs operated on and he never gets any chore service in our town. And he tries to carry one piece of wood at a time but when it's slippery he falls.

So I wish we could get some aid and help from Blue Cross and medicare to help us out. And I continue paying for his—I pay all his pension to the nursing home. I pay all his social security check. I pay all my social security check. So you see what I have left. I have a little pension that I can buy food. So I wish I could get some help and I thank you for listening to me.

Senator RIEGLE. Thank you Lydia. [Applause.] Pastor Aden.

STATEMENT OF PASTOR ADEN

Pastor ADEN. Senator, thank you again for these hearings.

So that you can get an idea of the extent and the depth of our concern, we have a lot of people from the Senior American Coalition who came as far away as Ontonagon. We had a bus to be here at these hearings. They have stayed, most of them the whole afternoon. I would just like to have them raise their hands please, so you can see. They are disbursed throughout the room.

The kind of a portion of people that are here because of the kind of deep concern—and I want to lay this not only on your mind. You have expressed your determination that we do not have to accept this kind of situation. But I also want to lay it on your heart and on the heart of our government because I think we do have a caring government.

I want to talk about a member of mine who at her 82d birthday threw a party for those she lived with in Heritage Manor in Houghton. She wanted to thank everyone for the love and the care that she was receiving there and express her appreciation for living in this kind of caring community.

Five days later Eleanor Alanon traded the nice two-piece suit and corsage she wore for that party for a hospital grown. She has congestive heart failure and she had another spell. But this time it was worse. This time they told her that neither her friends at Heritage Manor nor her family nor herself could adequately take care of her. She must go to a nursing home.

At that time all of her funds had run out. she was completely dependent on government reimbursements, on medicaid. Medicare said she had to leave the hospital. Where was she to go? Eleanor was told that she was going to be transferred to Florence, WI to a nursing home. And for Eleanor her joy of life ended right then and there because she was being exiled far away from friends and family and loved ones. For all she knew Florence, WI was in a foreign country.

I saw Eleanor in her apartment, which she called her little doll house just before she was taken to Florence. It was one of the most painful visits I have ever made as a pastor. For Eleanor, one so full of life and gratitude sat there now motionless. Her answers to me were just, "yes" or "no". She had nothing more to say. She believed it was the end. She had given up because she felt that her community had given up on her.

And this is typical of the many senior citizens that are being forced out of our communities because we do not have immediately available beds. And, just to conclude this case by saying that a relative of another person that we have given you documentation about has said this about here mother-in-law who was transferred to the Soo in the same kind of case. She said as soon as they go, they seem to have a kind of downfall. They think it's the end. And it was the end for her mother-in-law whe died 2 months after she had been transferred to the Soo. Please take this to heart.

Senator RIEGLE. Let me ask you this. Let's give him a round of applause. [Applause] We need to get adequate nursing home locations established. That just has to be done—in my mind, I cannot and will not accept the notion that that can't be done. My blood pressure goes up so fast that I don't even dare think about it too long—I just get too upset myself. Why can't we in the meantime see if we can't take some other steps to head this off. For example, there are people in the community that are living alone and older and may be able to be in their own homes but they may need help with chores as Lydia just said. Why can't we try to find a way to take some of those situations and get two or three people in the same house together obviously who are compatible but who are in a situation where maybe some additional help is needed for all the people in that house. I mean, part of it is the brick and mortar question of where are we going to put people if we don't have rooms in the nursing home. But clearly there are houses. I am wondering if we shouldn't start thinking in terms of alternative arrangement of some kind. Is that not practical. Is there no avenue that we should be thinking about as well?

Pastor ADEN. I appreciate—you know, what is needed is this kind of discussion as we share ideas together and we make different distinctions between people. Surely anyone we can save from this kind of fate we should do that.

Senator RIEGLE. It's like a death sentence in many respects.

Pastor ADEN. That's right and we have documentation from doctors who say this kind of thing. For example, this person I mentioned should have never been transferred to the Soo. In the long-term care study that our director Toni Kracke alluded to, there was a study about those people in the nursing homes. And we want to correct what may be a kind of a misunderstanding among the general population. People are in nursing homes because that is the only place where they can get the professional care that they need. And so we have many people—for example Eleanor's daughters held on until the very last. She was having spells, they were called over, you know, in the middle of the night. And so we have those situations as well where at this point only alternative is that. What we need is to look at the whole range—say the continuum of care and discuss this together. And I appreciate the struggle that I see you going through now in terms of what can we do about this.

Senator REIGLE. We can find answers. That much I am convinced of. This is a problem we can solve but there has to be a will to do it. People who can take action have to decide that this is important and that this is what we are going to work on and not on something else.

[The prepared statement of Pastor Aden follows:]

Senate Hearing on Health Care
Senator Donald W. Riegle, Jr.
August 28, 1987

Testimony of Pastor Ross Aden
Gloria Dei Lutheran Church
1000 Quincy St.
Hancock, Michigan 49930

A well-known expert on the elderly has stated that old age should be a celebration. One of the members of my congregation made it that. On her 82nd birthday, Eleanor Alanen threw a party for her fellow residents at Heritage Manor in Houghton. She wanted to thank everyone for being so kind to her.

It was a picture of the way that we would like old age to be. There sat Eleanor in a two-piece gray suit with a corsage. Surrounding her were her family and friends and neighbors. Eleanor was home, in a community where she was known, cared for, and loved. Life was a celebration.

Five days later she traded in her gray suit for a hospital gown. She had congestive heart failure and had another spell. This time she could not go back to what she called her "little dollhouse," her apartment. She was totally dependent on government reimbursements at that time. Medicare said that she had to leave the hospital. But her health was so poor that neither she herself nor her family could take care of her. Besides that, her daugher in the area was in poor health herself and was facing surgery.

Eleanor was told that she was to be transferred to Florence, Wisconsin--to a Nursing Home there. For Eleanor life as a celebration ended then and there. She was being exiled far away from her home, her community, her loved ones for all she knew to a foreign country.

I saw Eleanor in her apartment just before she was taken to Wisconsin. It was one of the most painful visits I have made as a pastor, for Eleanor, once so full of life and gratitude sat motionless with the faint trace of tears in her eyes. Her answers were just "yes" or "no". She had nothing more to say. She believed this was the end. She had given up, because she must have felt that her community had given up on her.

This is typical of the many Senior Citizens who are being forced out of our community against their will because we do not have immediately available Nursing Home beds when Medicare hospital funding runs out. The relative of another old person who was shipped away from us, Antoinette Brouilette, has observed, "As soon as they go, they seem to have a downfall. They think it is the end." For her mother-in-law, it was. She died two months after having been taken to the Soo. The doctor who examined her there said that she should never have been transported that far in her condition.

I speak as a professional who must care for our aging population. In each case like this we have a catastrophy, one that is caused by government regulation and can only be solved by government. And long term illnesses that require Nursing Home beds that the government will not allow us are not only catastrophies for the old persons so mistreated. But they cause severe hardship for their families who feel guilty enough already that they can no longer care adequately for their loved ones. We are causing our families to endure the financial hardship and emotional trauma of having to stay overnight in motels if they want to visit their mothers and fathers in old age because we ship them so far away.

We have here a failure of the system which relates to Medicare which limits hospital stays (even though a more extended stay might save transporting an older person away for a month and then back when a bed in the area opens up) and of Medicaid which pays for over 70% of the Nursing Home costs in the state.

In short, I want to testify that we are killing our old people in spirit and sometimes in body because of DRG's and bed need methodologies and all of the well-intended policies which do not take into account the unique needs of the citizens of the U.P. and which need to be modified accordingly.

We ask you, Senator Riegle, that you look into this matter, include it in your proposals, and help the government work out a solution.

Senator RIEGLE. [In response to woman in the audience]. Yes, step up to the microphone.

STATEMENT OF CAROLYN GUILI

Mrs. GUILI. What gets me sick is that the Portage View hospital has four floors that are empty. And it's about time that we filled them up with these poor people. And another thing is, medicaid will not pay any patient that wants to go out of the State for help and that's terrible and I have a daughter in that situation. I have written to you before. Eighteen doctors couldn't find out what was wrong with her and she had low blood sugar. I had to go to Cleveland and spend $14,000. It breaks my heart. St. Joseph Hospital isn't St. Joseph Hospital anymore. It's got so many what you call levels there that are empty and it's time for something to be done about it. We don't need to have temporary services that can be in there.

Senator RIEGLE. Let me ask whether there are any other people who are going to be taking the bus back. If you are moved to say something—he wants to say something. Do you want to speak from there or do you want to come up to the mic?

MAN. I'm one from Ontanogan County. White Pine has a hospital—there is nobody in there. Why can't we put a nursing home in there. Why can't we use that. Why can't we put nursing homes in these empty hospitals?

Senator RIEGLE. That's the kind of logical answer I think we have to find. We have to use what we have to work with. In addition very often on these hospital grounds there is room. If you were going to build a nursing home facility, if you have it close to the hospital there are certain efficiencies. People can be adjacent to where they may need more care in a special situation. I think there is a way to start the conceptualize something new. We need something different from what we have got. The nature of the problem is changing. What we are hearing today is that we are finding that the bureaucracy and the old way of thinking about this problem doesn't fit what's really happening anymore, that things have changed and we need to make some major adjustments.

If we just try to fit today's problems back into the old structure it doesn't work. People say it in different ways—people are falling through the cracks, people are being sent far away from home which in effect becomes a type of death sentence. We need to collect this problem in a new way and then decide what the answer is. It may very well be using these open spaces in the hospitals or adding wings onto these hospitals But this is why we are here. We're here to get these things on the table so we can figure out what's going on and what we need to do about it. I want to say again for the group who has come from a great distance and I gather is going to have to leave very shortly how much I appreciate all of you coming today and being here, whether you have actually spoken and given testimony or whether you testified just by being here in person, which is just as important. Is there anybody else who is going to have to leave who wants to say something? I think

this gentleman here would like to speak. I am going to ask you to speak into the mike.

STATEMENT OF VERNE ROWE

Mr. ROWE. I am from Laurian and I am a member of the American Association of Retired Person's State Legislative Committee. On the issue of the swing beds, there is a temporary way that this can be alleviated. If the legislators in Lansing will see to the passage of House bill 5—I think it is 5143. It's called the swing bed bill and what it would do would be give the patients a right to be put in a hospital, a local hospital, instead of sent away to Wisconsin or the Soo or wherever it is.

Now this has been in the legislature—I don't know—this is the second or third time around and they still haven't acted on it. And I think the only way we are going to get anything is if the people get aroused enough to let the legislators know that, never mind sitting down, get up and put this thing through. We are tired of sending people away. And if we can do that maybe we can get some action. The Federal Government has passed swing bed legislation but not every State has adopted it. Michigan has not and until we can get Michigan to adopt it we are going to continue hurting.

The buildings are there. There wouldn't be any construction costs. There is trained people available. They are out of work, they are looking for work. Instead of being unemployed they can have a job that will help our tax base and everything else. But the most important thing is that it would keep the people in their own communities until a local nursing bed came up. We have to think of people as individuals, not as a number in a quota system. We must do it. Senator, I don't know what you could do to get the State legislators to act on this but whatever effort you could put forward would be greatly appreciated. It's something we need.

Some places down State have a surplus of nursing homes. But it's bad enough shipping them 200 miles to the Soo instead of 500 miles to lower Michigan. We are unique in our needs maybe but that's where the quota system is no good.

And once before I go I would like to say one more thing, the American Association of Retired Persons fully endorses your catastrophic health care. We are 100 percent behind it. We need it. As a matter of fact I am going to read something here that is a message I am supposed to convey to you anyhow. It says "Recently received the letter from AARP asking you to contact your U.S. Senator to urge the immediate consideration of Senate Bill 1127, the catastrophic health care bill when the Senate reconvenes in September. Sponsors of this bill tried to bring it before the Senate for a vote prior to the August recess but because of a negative campaign waged by the pharmaceutical industry they were not successful. The pharmaceutical industry is strongly opposed to medicare coverage of prescription drugs and is now lobbying your Senators as well as your general public to persuade them to oppose this important new benefit. This is a crucial time. Members of the Senate must know that the pharmaceutical industry does not represent the views of older Americans."

Our organization, both statewide and nationwide is in complete agreement with you on the three parts of the bill. If those could be passed it would mean a great great benefit. I have neighbor who is Medicare coverage—she has Blue Cross Blue Shield and she is still spending over a $100 a month out of her own pocket on medication. And how much longer she can keep on doing it I don't know. But that poor soul deserves more than having to go on medicaid or something like that or move out of her home because of her drug bill. And I want to thank you for everything you have done for us. We appreciate it and keep up the good work.

Senator RIEGLE. Well let me thank you for everything you have done for this country. I think we've got one more gentleman and then I gather the group that came on the bus is going to go. Is that right? I would love to have you to stay but I gather that is the case.

STATEMENT OF ARVO PYORALA

Mr. PYORALA. I came on the bus too, but I want to thank you Mr. Riegle for coming down here. I wrote to you many times because I am the voice of the senior citizens in the copper country. I am Arvo Pyorola but in the copper country I am better known as Radio Hotline Charlie. So with all this testimony that I have heard from different people I am going to cover everything here, not only the hospital beds.

You know the catastrophic health insurance has a long way to go to take care of the needy. Although our President Reagan spoke about the national health care and the catastrophic plan, he said we took a long step forward. However Claude Pepper of Florida who always has been an advocate of better health of the Nation said it is only a pigmy step that Reagan is proposing.

It was also brought out that in the catastrophic medicare program we should include prescription drugs which is really robbing the low income people. You know, I myself paid last years $1,295 for prescription drugs alone. I put a one dollar patch on my chest everyday on acount of my angina heart trouble. That really hurt my income.

And now let's consider the younger generation who are not on social security and medicare and have no health program and most of them lost it on account of losing their jobs and the company was paying for their health insurance. But now when they are on low income wages they can't afford their own insurance. How are they going to cope with a long term illness? That's why we need national health care in the United States. I have been an advocate of that kind of program for years and finally I will say Canada and a lot of smaller countries throughout—although ours—has a better health care than we have. What we have—I do advise our Senators and Congress to start promoting a national health care for our good old United States and thank you very much. I could explain quite a bit more but——

Senator RIEGLE. I can see why you are the voice of the copper country.

STATEMENT OF BERNICE JAMES

Mrs. JAMES. I'll just take 1 minute. I have a catastrophic illness myself. I have cancer and I got that cancer from the reserve Mining Co. putting the polution into the lake. And you will be having a hearing next week on the confirmation of C.—what's his name again—V-E-R-I-T-Y. So I am asking you please do not verify Verity. Because of him and his board of directors of the Reserve Mining Co. that put that pollution in our most beautiful Lake Superior, polluted it, and put the fibers into the lake. And I feel—I've lived in Keweenaw all my life. It's that peninsula that goes right up into Lake Superior. And we were really devastated by all that pollution that came into the lake because we were sticking up into Lake Superior and I feel as if I got cancer from that. So I am hoping that you will use your power and talk to the other legislators and not verify Verity as a Department of Commerce head. And I thank you most kindly for coming.

Senator RIEGLE. It's really nice to see you and I appreciate what you've said. Let me thank all of the folks that were here that have to catch the bus. Thanks so much for coming. It's been great having you. I appreciate the testimony and I appreciate your presence. Now, I am going to go down through the list of those who have indicated they would like to speak. I know some will have gone because of the lateness of the hour or because they are on the bus. But we are going to hear from everyone who has asked to speak. So, let's find out who's here and who is waiting to speak. Cynthia Nighquist. If I call your name and you are here I am going to ask you to speak up so that I know. I gather she is not here. This is a gentleman from Hancock—Eli Mylanin. Kathy Kumkoski, all right, you will be next. Do you want to come on up. Bill Clark. Bill why don't you come on down. You will be the second person to speak. Kenneth Siegwart. Gino Beltrame. Still here. Mike Coyne has spoken. This is a hard one Coibson, from Big Bay. Grace Gibson, I beg your pardon. Grace, excuse me it's your writing and my eyes, probably more eyes than your writing. You will be third here.

Verne Rowe. Luke Foresburg. Candy Layton. Robert Aho. Robert followed by Roy. You are Roy. OK you will be next. Manfred Tatzman. Tatzman. Please excuse the butchering of these names. Pastor Aden spoke. Rosalie Stevens. Rosalie you will follow. Tembruell, John you will follow. Dr. Jacquie Jaaskelainen. Is she here? Jacuie, we will be pleased to hear from you. Betty Holman, is Betty Holman here? Ken Baker. Sandra Spoelstra. Jacqueline Dault. Yes, very good. Elizabeth from Ishpeming. How do you pronounce your last name? Junttig. OK, Sven Johnson. Arnold Williams. Is Arnold Williams here? Evelyn Erm. David McMahon. Marian Guelff. That's who I have. Am I missing anyone? If I am, identify yourself so you can get on the list.

All right. Kathy. They can't hear you speak right into the mike, and I'm going to ask our technicians to turn up the mike.

STATEMENT OF KATHY KUMKOSKI

Ms. KUMKOSKI. I am from the Area Agency on Aging and our mission is to keep people out of nursing homes as long as possible.

We administer services to the 61,000 people over the age of 60 in the Upper Peninsula through 90 senior centers and nutrition sites. And, as I said our mission is to keep people out of nursing homes for as long as possible. Older people are afraid to get sick and they are afraid because of the cost of getting sick.

The State Office on Aging had their meeting—the commission—had their meeting here at Michigan Tech. on Tuesday and much of these same concerns were raised at the forum that they had up there at that time. The number one priority in Michigan is health care and this was backed up by a survey from the university of Michigan and this proves that older people are concerned about health care.

Currently we have three day care centers operating in the Upper Peninusula with donated funds, private funds, donate time and a handful of Federal dollars. But we do have a start. We sympathize with the needs of the Alzheimers caregivers. We trained 22 respite care givers but ran out of money and that's over until we get some additional money.

Three hundred senior citizens met on Wednesday and we endorsed these 10 resolutions. And the resolutions range from a need for assistance with their medications and the second resolution addresses the need for catastrophic insurance. We have looked at the Federal proposals and we see that you are taking a step forward, a step in the right direction. But we feel that the Federal proposals don't go far enough. We think that the Federal proposals should include nursing home care and in-home care. Thank you.

Senator RIEGLE. Thank you, very much. I got a little disconcerted when that cup of coffee spilled. Did I call Bill Clark next or did I call a different name? What is your name yes I see I think you follow Bill. Bill is that you?

STATEMENT OF BILL CLARK

Mr. CLARK. Senator Riegle, first thanks for the opportunity of being here today.

I apoligize for digressing slightly. This is a particularly individualistic issue. My family and I always felt that we were adequately covered by insurance and whatnot. I was on active duty with the U.S. Air Force until last year when I separated. And, we've always depended on medical care through military facilities supplemented by CHAMPUS. However, since I separated last year, coverage was maintained through various insurance carriers.

However, about 1 year before I separated while I was still in the military service my wife developed a specific medical problem, sought treatment. After about 6 months of various tests and unsuccessful treatments the only recourse was going to be major surgery. I had no control over my separation date and I separated without her achieving that treatment and her CHAMPUS and all entitlements were thus terminated.

All insurance policies we have had since then have not covered preexisting conditions and we have made several appeals to the military to at least complete the care that they had started. Those appeals were fruitless. We have just now acquired some coverage which 6 months later from now—if my wife lasts that long—it's

not that serious but I mean her suffering is still—6 months is not to be desired—6 months from now preexisitng conditions will be met.

Like I said we have made several appeals to the military through various offices for them to reconsider. There are provisions for the military to continue treatment, however it is at the convenience of the government such as providing for training of their personal, etc. etc.

That's all I have, Senator Riegle. I solicit any support you can give in expediting my wife's return to health.

Senator RIEGLE. OK I want you to talk with Karl who is going to be coming in here in just a second. Thank you, Bill Grace. As often happens, we are running long because a lot of people are here and want to speak. A lot has been said today. But I am going to ask everyone to summarize as much as they can because I want to get through everybody and at some point I am going to have to leave because of another event that we have to take a role in. We are going to continue the hearing. I am going to have Joan take the testimony, if anyone hasn't spoken by the time I have to leave. If you can all consense as much as you can that will help us get through. Grace.

STATEMENT OF GRACE GIBSON

Ms. GIBSON. What I have to say, Senator takes 2½ minutes. Senator, ladies and gentlemen, my name is Grace Gibson. I am the mother of Leon Gibson, a quadriplegic and a senior at Northern Michigan University.

I would like to speak with you about one of the many difficulties faced by Leon in his effort to become an independent, productive member of society. Leon has not had a new wheelchair—electric wheelchair—for 8 years. For a quadriplegic, an electric wheelchair is the single, most important piece of equipment to make him into society. It takes that independence and mobility away from him without one. Since Leon's chair is old, it breaks down, makes it unreliable and makes Leon unable to get out for days at a time while repairs are made.

Leon is a senior at college. He needs a new chair. It is to society's advantage that he have one. With an electric chair, Leon can finish his education and get a job. This will allow Leon to be a taxpayer rather than a tax recipient, and the investments that the public agencies have made in him can become productive.

But, without a chair, Leon cannot seek or maintain employment. Leon has medicare and medicaid. If he had medicaid alone he could get an electric wheelchair. Under the guidelines, medicare will pay 80 percent of the allowable for a new chair. This means that if the new chair costs $4,000 to $5,000, the allowable is $3,000. Medicare will pay $2,300. And the companies therefore cannot sell a chair that is considered personal investment and Wright-Phillips will not do this.

Leon's old chair is not going to last much longer. What will he do? Will his degree mean nothing? I don't know, but it is my hope that the government will do something to revise public insurance

policies to better serve Leon, and all of us who are caught in the system.

Senator RIEGLE. Thank you, Grace. We will see what we can do to help on that as well. Roy.

STATEMENT OF ROY AHO

Mr. AHO. My name is Roy Aho. I live in Trenary, MI, rural Upper Peninsula. I am a fire department person, volunteer and first responder. I am also an educator.

I have got three different areas I would like to bring up. One is medicaid. For people who have medicaid full family card they have very much difficulty getting in to get service. In the rural area it requires a trip to Escanaba or Marquette or Munising where the doctors and medical care are. Many of those doctors will not accept additional medicaid patients. Some also will not accept medicaid patients over a certain age, say 16 for dental care.

OK I feel that medicaid isn't doing the job as it currently exists. It's not—people can't get care even though they have medicaid coverage because they can't get in to a doctor in a timely fashion at a reasonable cost, in telephone calls and in travel to get there. OK, that's one area I feel we need to work better with the existing system. I don't have the answers but I am hoping that you do.

OK, second thing. I feel we need some kind of national health care coverage or plan for everyone not only catastrophic, but all others also. There are many people that I am familiar with who don't have any medical care coverage whatsoever, none. And those people are working. They have jobs. Their jobs are either the kind where they're relatively unskilled. These people may be relatively uneducated and they don't have the finances to buy the services. The very poor can get it under medicaid or medicare, the very rich can buy whatever they want because they are not medically poor. So those people need some kind of a plan to enable them to get day to day medical care so they don't have as many catastrophic problems. If the problems are taken care of right away they don't become as catastrophic.

OK, the third area concerns a relative of mine who is deceased. Her husband was military connected, diagnosed with multiple sclerosis. He was in the VA hospital in Iron Mountain for 4 straight years. I know what bed sores look like. He died. She took care of him while he was there. And after he died, her income because he was no longer living, were cut back and she took a job and went to work. This job did not pay much money and she could not really afford to have her own additional health care plan but she was included under CHAMP VA medical care. But it required pretty much as far as we could tell hospitalization.

She got sick. She wouldn't go in to the doctor because it would only pay if she went to the hospital. Well finally she got sick enough where she went to the hospital for 8 days. She died.

OK, we are now as children and relatives, faced with hospital costs. CHAMP VA did not cover all of respiratory care, anesthesiology and radiology. OK, the reasonable rate according to CHAMP VA is X amount of dollars. I won't go into all the figures because it will take to long. OK, they say they will pay 75 percent of X, the

reasonable cost. But the doctors'—respiratory, anesthesiology, radiology, what have you—figures come out X plus Y—some other amount.

OK, VA will pay 75 percent of *x* so the individual's amount due is 25 percent of amount *x* plus that big chunk called *y*. OK, when CHAMP VA says the fees are higher than reasonable, who does the person who has to pay the bill complain to? How much pressure can an individual put on a doctor or a hospital to lower their fees or how much individual pressure can we put on CHAMP VA to raise their payment rates?

OK, there's is a big difference there—the individual holder is holding the bag and she is no longer with us. Her children have now these bills and doctors are saying pay this or we are going to collect it—go through a collection agency or take other means.

OK, should the family of this deceased person have to pay these bills they would have to sell the only property that she was able to accumulate and hold which was her household goods and her house. So they are faced with a bill that they either pay out of their own budgets or out of the sale of the household that was the only thing she ever accumulated in her whole life OK, I have a copy of those figures for you.

The third area that I wanted to mention, just bring to your attention was the fact that recently social security benefits—direct payments under social security—and it was increased and it was increased on a percentage basis. So those people who had big social security incomes, let's say a $1,000 a month just for a round figure, if you increased it 10 percent they would get $100. OK, if the other person on the other end was receiving $100 a month, that person gets $10. Which person really needs the increase? I say the person with the lowest income really needs the increase. They should not be on a percentage basis, they should be on an actual dollar amount increase or on a degressive percentage basis so that the person who has a $100 income of Social Security a month gets the $100 and the person with the $1,000 a month gets the $10. It goes to the person who needs it most. But it doesn't seem to work that way.

OK, these are the three main areas I wanted to bring up. There is no one looking after the person under any insurance provider when the difference between what the doctor and hospital charges think are reasonable as compared to what the insurance company says are reasonable. Who do we complain to?

Senator RIEGLE. Well you have just complained to me and that's a good place to start. I don't take it as a complaint, but I am glad you brought it to my attention. The system today in many respects is designed not to work and there is a lot built into it, like the 80 percent of *x* and the zero of *y* that's a deliberate attempt to squeeze people out of the protection and the coverage that they need. I don't think that there is any real justification for those arbitary percentages and standards of what constitutes a fair price for the service that is given. My own feeling is that it is based on an effort to force the cost down regardless of what the effect is, and it shoves it back on the person who, as in the case that you've cited, is just not in a position to pay, not without devastating the situation more than it already is.

I am going to have to excuse myself in a minute. We have nine more people who have asked to testify. We are recording everything that is being said which is what the gentlemen in the back of the room are doing, so that we have a full committee record. Everything that is said after I leave the room is part of the record and I will hear it. I don't want to have to leave. We have had a lot happen here today and more people came than we thought would come. I am going to have to go in just a minute. I know this gentleman wants to say something and you want to say something and everybody wants to say something.

MAN. There's a gentleman here who has been waiting and by the time he gets to talk to you, everybody is going to be gone. That's par for the course. I mean it. Every meeting I have ever been to——

Senator RIEGLE. Let me stop you for a minute. Did you want to make a statement.

MAN. I'm waiting my turn.

Senator RIEGLE. Well, let's hear from the gentleman that you just spoke to. Why don't you go ahead. I want to hear from you. I want to hear from everybody here.

STATEMENT OF DAVID McMAHON

Mr. McMAHON. My name is David McMahon. I am an ex-marine.

I was in a car accident due to a disability that the Marine Corps gave me—an unsuitable personality disorder they call it. They say I have a bad attitude. They gave it to me. But, I am not entitled to anything for this. All I do is get fired from jobs, get pushed away from people for it and I eventually caused an accident.

Since my accident, I can't get proper medical care in this town. I have to go down to Marshville now in Wisconsin to get treatment. I can't even get medication out of the VA anymore because of the so-called drug rehabilitation attitudes that the VA has started. They don't give medication to out-patients unless they are Vietnam era veterans that are suffering.

I had the left side of my body smashed and my balls. I am in a lot of pain, severe pain, right now. I don't get nothing for it. I can't afford to buy anything. And I found out it is illegal for me to make my own.

All I want to know is what's happened to life, liberty and the pursuit of happiness in this country. I get told what I am allowed to do, what I am not allowed to do, where I can go, and I don't like it and I ain't going to put up with it. I wouldn't kiss up to the doctors in the VA so they had their security guards take me out when I protested that they wouldn't give me the operation I wanted and that they only did what they thought was necessary to keep me alive. Well there is more to life than just staying alive.

Now I just feel bitter. They say I was suicidal. I am not suicidal. If anything I will get homicidal before I get suicidal and I just feel like I ain't got nothing. You are talking about health care, I ain't got enough money to eat because I have to be on welfare. They don't give you enough money to eat. And then when I was in the hospital here, when I come out of the hospital, the first letter I get is from the social services telling me that I am cut off because I

didn't fill out a form, that I wasn't getting until I went into the hospital. I went and called the caseworker when I was in the hospital to tell her I had been put in there. So what did she do? Immediately she sent out a monthly report form to my address with a stipulation that it had to be returned within a certain amount of time which I was unable to do. So somebody had to illegally pick up my mail to bring it to me so that I could do that so I wouldn't get cut off.

Now I have applied for social security disability. That's a good one there they turn you down first six times even if you are in a wheelchair. You've got to be willing to shed yourself of all human dignity to get your social security disability. Then it's less than what they used to take out of my checks when I was drilling for oil in the Gulf of Mexico. They've given me less than what I put in.

And you talk about senior citizens, I used to live across the street from that highrise building. Most of them people are in there because they were forced out of their homes. You talk about getting them all together—well they are all in there. They don't—you know—it takes a long time for them people to get close to talk to each other. Most of them stay in their own apartments. And like you say a lot of these people need help.

I live out there in Little Lake now because I had to move out in the woods because I can't afford to live in town because it costs too much. Those people out there they couldn't get in. Talk about people coming in for this hearing, very few. They don't even have an ambulance driver out there for their township or anybody that's qualified. If they went to a house where somebody was having a heart attack that person's as good as dead because they don't have anybody to do the job.

In summary, what I am saying is that they just don't have what they say they do up here and doctors shouldn't have the right to lie to patients either. If there is something wrong with somebody they should tell them.

Senator RIEGLE. Tell me what your name is again.

Mr. MCMAHON. David McMahon. Right on the bottom of your list.

Senator RIEGLE. OK, David, let me review your situation and see if I can help.

Mr. MCMAHON. I have even applied for Veteran's disability. That's a joke. They told me they would answer me yes or no by January 18 of last year.

Senator RIEGLE. And you haven't gotten an answer?

Mr. MCMAHON. No; I don't get any answer from them.

Senator RIEGLE. Let me see if I can get an answer.

Mr. MCMAHON. It will probably take something like doing anything.

Senator RIEGLE. Well, whatever it takes. Let's try and see if we can make it work. I would like to help you.

Mr. MCMAHON. I would appreciate it.

Senator RIEGLE. I appreciate the fact that you served the country and you obvious need help so let's see if we can't get some.

Mr. MCMAHON. Yea, they don't want to give out any of the benefits they promise. And if you ever protest anything they do in the

VA or say anything against them they call their security and have you escorted out of the building.

Senator RIEGLE. Let us see if we can help you. I like to help you.

Mr. MCMAHON. I have trouble controlling my temper because of nerve damage.

Senator RIEGLE. Well, sometimes that happens to all of us. So, let's see if we can't help each other. I mean this is America. We shouldn't have to be at war with one another.

Mr. MCMAHON. Yea, but you can't help a man build a farm unless there are carpenters in this country.

Senator RIEGLE. Well let me see if we can't help you.

Mr. MCMAHON. That would be greatly appreciated.

Senator RIEGLE. Let me say to everyone else here, I know everybody has been very patient. Let me ask this, is there anybody else who is in a kind of emergency situation as he has just described where you have got an individual problem that you feel you desperately need help with? Is there anybody in that category?

MAN. [Off microphone]

Senator RIEGLE. Well, I don't think we should be getting into that. That's not what we are here for. But she doesn't look as if she wants to speak now. May I ask with respect to the rest of you, under the circumstances that we are in, would you be prepared to go ahead and give your statements even though I must excuse myself with the understanding that I will go through them each individually. If you feel the need to talk to me personally I will get back in touch with you.

Mr. TATZMAN. If we could talk about children services. We have heard a lot about senior citizens. I would like to just quickly represent about 3 minutes worth of children issues.

Senator RIEGLE. OK. What about the others on the list here whose names I have called? Rosalie Stevens. Would you be prepared to make a statement after I have excused myself. That would be very helpful to the record and to me. Please understand one thing. You are not just talking to me today. You are talking to me but you are talking to the Budget Committee and you are talking to the Senate and I intend to take every word that we get today whenever it is said and however it is said including the written statements of which there are several here and disseminate it. The problem is we made a commitment to participate in an activity related to precisely what we are doing here. So I feel some obligation to that as well. You will make your statement here in due course. John Tembrill. Is John here? I guess John has left. Dr. Jaaskelainen. Yes. Jacqueline Dault. Elizabeth Junttij.

[A woman indicates a personal problem off-microphone].

Senator RIEGLE. Have you been working with us in our office to see if we can help in some way? OK I appreciate you doing that. Sven, would you be willing to make any additional comments for the record like the others. [Sven indicates he would.] Thank you. Marian. [Off-microphone]. You are exactly right. It takes an administration that wants to do it and I am going to have to tell you bluntly I don't think we have one today and I hope we will have one shortly because that's really at the heart of that problem. Would you be willing to make those comments for the record? [She

indicates she would.] All right, very good. Max Engel. Thank you, Manfred.

STATEMENT OF MANFRED TATZMAN

Mr. TATZMAN. I appreciate the extra few minutes because I represent the 31 member agencies of the Upper Peninsula children's coalition and we represent the children's concerns.

You have heard a lot here today regarding senior citizens but we also have some concerns. We believe that an illness does not have to be catastrophic to be disabling and a financial disaster for a family or individual. From our perspective, the Senate needs to examine the gray areas of health care protection in which insurance coverages terminate or subside and public assistance programs fail to kick in.

The Upper Peninsula Children's Coalition representing 31 agencies does not want to represent a litany of horror stories. Rather we would like to discuss problems, situations and dilemmas. We believe that the Senate should address the entire issue of relatively accessible comprehensive health care for the general population regardless of age, ability to pay, or geographic location.

We urgently need to address the issue of a single point of entry for health care where families can go not for only catastrophic illnesses but also routine care for chronically involved youth with significant ongoing medical needs including substance abuse. We need legislation which will provide the ongoing medical expenses such as home health services and especially transportation to get the medical care for us in the Upper Peninsular, maybe Petoskey, Ann Arbor, Green Bay or Minneapolis.

The concept of the DRG's system needs to be expanded to provide services outside of acute care settings, since many people are returned home earlier.

The financial and actual burden of care has been shifted to the family and the individual. Therefore, we need to provide for ongoing medical care and services to keep individuals at home with help. Catastrophic health care insurance is just the tip of the iceberg. We need to provide ongoing affordable medical coverage for all Americans.

The Upper Peninsula Children's Coalition's primary concern is for children. Yet, when catastrophic illness strikes, its effect can be felt by the entire family. We have contact with families who are employed with the very basic private medical insurance which does not cover such things as prescriptions and therapies for their handicapped child. These families' incomes are high enough to place them outside of the eligibility level for assistance. However their income is not sufficient to pay for needed medical care.

We have a family who for a variety of reasons ended up in bankruptcy following the death of their 3-year-old medically fragile child. Factors to consider in this case were prescription cost for medication, oxygen, specialized equipment, respite care, problems with parental alcoholism.

Families are often placed in jeopardy because we do not have legislation that will cover the needed or required surgery to enable heads of households to work or return to work. Most American leg-

islators would agree that we need to encourage all people to work and become self supporting. However, one of the biggest obstacles is ongoing affordable medical coverage. Individuals on public assistance in many instances can not return to work even though they want to because lack of medical coverage at their proposed place of employment. We believe the system should support and encourage those willing and able to work.

The term catastrophic care should be changed into something positive like comprehensive care. We need to emancipate families and individuals from the anguish, agony, and fear they may face by the onslaught of cost and care of catastrophic illness, a system that provides not only the required acute care but also cost of prescription medicine, specialized equipment, respite care, transportation, and home health care is needed. This comprehensive care would include those individuals who fall under the need of comprehensive care due to substance abuse problems, specificaly adolescents. The Upper Peninsula Children's Coalition is willing to endorse legislation that will provide for comprehensive medical care for families and individuals to help them avoid being placed in a catastrophic health care setting.

Thank you for asking the Upper Penisula Children's Coalition to participate in this hearing.

Ms. HUFFER [For Senator Riegle]. Thank you, very much.

[Additional children's coalition statement follows:]

MEMORANDUM

TO: Sen. Donald Riegle

FROM: Francis van der Maarel, Drs.
Marquette SODA Counselor
Marilyn Cook, MA, Prevention Coordinator
Eastern UP Substance Abuse Services
Danny Peterson, Director
Project SODA
Honorable Michael J. Anderegg
Marquette County Probate Judge
Pat Tikkanen, MSW, Substance Abuse Program Director
Marquette General Hospital
MaryAnn Wodja-McCloud, MSW
Shiloh Family Director

RE: Statement to be used for incorporation into UP Children'sCoalition statement to be presented at the Health Care Hearings on behalf of the Senate Budget Committee

DATE: August 13, 1987

We are fortunate to have obtained in 1983 the inpatient adolescent substance abuse treatment unit at Marquette General Hospital. Many of our chemically dependent youth are successfully completing this program, at which time, lifelong recovery begins. Some are not able to complete this program because in addition to their chemical dependency, there are severe behavioral problems. Most adolescents are discharged to their family of origin and many of these parents are not able to support the recovery program of their youngsters. This inability might be the result of a combination of factors such as

- -the necessity for a change in lifestyle
- -the time and cost involved in transportation to and from youth support group meetings (AA and NA) and other community resources
- -the parent is disabled
- -the youth is in need of extended care such as Shiloh Family.

The UP does not have a continuum of care available to sustain the recovery of our chemically dependent youth. (An estimated 50 youths per year are discharged from the Substance Abuse Adolescent Treatment Unit at Marquette General Hospital who should have been discharged to a continuum of care services instead of to their parents.)

A. <u>There is a need across the Upper Peninsula</u> for consistent quality aftercare counseling and support services for families of recovering youth who return to their parent's home.

B. <u>There is a need for funding for extended care, e.g. Shiloh Family.</u> Most insurance agencies do not pay for extended care services like Shiloh Family. County court systems don't have enough funds available to allocate for their wards needing this type of extended care. Most parents are not affluent enough to provide this costly care (at approximately $17,000 per six months)

C. <u>There is a need for group homes/halfway houses for recovering youth.</u> They do not exist in the UP. Those services are available in Minnesota at exorbitant costs to the parents, e.g. $84/day, and thus not available. Seventeen year olds, who might be eligible for emancipation and/or general assistance via DSS, are not admitted to the adult halfway homes since in this respect the 17 year old, emancipated or not, is considered a child.

D. <u>There is a need for specialized foster homes</u>. These homes could be under the supervision an extended care facility and could provide care most closely resembling the youth's home environment. If they were created, we have no system in place that would provide the funding.

In summary, the UP does not have available the facilities, services or funding to sustain the recovery of chemically dependent youth.

Michigan law regarding the status of 17 year olds as an adult versus child needs clarification, not only in regards to the disease or chemical dependency, but also in regards to being able to obtain any medical treatment as well as health insurance when they no longer live at their parents' home.

Ms. HUFFER. Rosalie Stephens.

STATEMENT OF ROSALIE STEPHENS

Ms. STEPHENS. I have nothing prepared, but I would like to give a brief statement. My heart breaks for some of the things that I have heard today, in reference to the senior citizens but there is another group that needs funding desperately.

There was excellent testimony given today by Pam Talono the president of the Upper Peninsula Head Injury Organization, also by Dr. Coyne and Carlyn Rapport affiliated with Marquette General Hospital.

I am the mother of a 29-year-old traumatically brain injured son. He was hurt 2 years and 7 months ago in Seattle. The prognosis at the time that he was hurt was that he would be a vegetable. That same son today, whom we have at home, is walking, talking, takes care of all his personal needs.

The last therapy session lasted for 9 months. We live in a remote area and so I would come here to Marquette, 125 miles on a Monday, and stay throughout the week with him at a motel and go home on Friday night. I have become a weekend wife.

I am not knocking the medical profession when I say the prognosis in the beginning was that he would be a vegetable. There is so little known about brain injury. Funding is needed desperately for rehabilitation. People that are diagnosed as maybe never going to be functional human beings, indeed with intensive rehabilitation could again become functioning people in our work community if the funding were available for them to get the intensive therapy that they need. Those people could be taken off of welfare rolls so to speak. We wouldn't need the monies that we will possibly need for entire life time. We are talking about millions of dollars when it comes to head injury. If the money were made available for intensive rehab, perhaps in 4 or 5 or 6 years that person could be working.

As I said my heart bleeds for the older people because for one thing it is frightening. I am 52. I don't have long to go before I am going to be considered a senior citizen. But funding is needed desperately for other people in other categories. Thank you.

Ms. HUFFER. Thank you. Dr. Jaaskelainen.

STATEMENT OF DR. JACQUIE JAASKELAINEN

Dr. JAASKELAINEN. I am Jacquie Jaaskelainen and rather than go into a case history I will give more a summary remark and speak to the three areas that medicare does not cover.

Number one is the doctor's fees of nonparticipating doctor's. The patients with these crippling diseases need the care of specialists and they have to go out of State to get them. And most of the time, their specialists are not these participating doctors like the lady who had to go to Green Bay. In the case of my father, he has to go out of State for his operations on arthritis. He has had 11 major operations on his joints, cancer operations and others. And he has to go to the out of State clinics because they have to control the cortisone and make it accurately regulated to survive the trauma

of major surgery. And something needs to be done to encourage these doctors to be participating.

Second, the payment of diagnostic tests are not covered for the proper evaluation.

And in summary I will just speak to the coverage of prescription drugs. At present there isn't any. A senior citizen who is on social security receives $404 a month and the prescription drugs for rheumatoid arthritis will take half of that amount and sometimes all of it, just for the prescriptions alone. And there are many people on limited incomes that are not getting the care they need because they can not afford it. And we know it is unrealistic to ask for full coverage at this time but a step in the right direction would be House bill 2470. This bill was passed in the House on July 22 and it had in it a prescription drug plan and now Senator Riegle said he is going to include that in his, this new bill that is coming out. And I hope it is in there because these senior citizens that are on these critically crippling diseases desperately need prescription drug coverage.

So in summary there must be a—this is the most important thing that we can do, is to provide care in hope for the citizens to live out their lives in dignity and free from this economic stress that accompanies a long-term illness and it must be done on a national level. Thank you very much.

Ms. HUFFER. Thank you. The Senate is likely to take up a prescription drug amendment when the catastrophic legislation comes to the floor. As you heard earlier, there has been some objection from various industries to that amendment. This has been one of the things that's delayed taking the bill to the floor. But there is very strong support for trying to include that benefit and hopefully it will be included this fall. [Off mic.] Not currently but there is an amendment that a number of Senators including Senator Riegle have been developing to offer on the floor when that bill does come up for consideration. They are going to try very hard to include it. There is support for including it and since it is in the House bill, even it it is not in the Senate bill, there is a good chance we could get it into the conference agreement when the House and Senate comes together to resolve differences between the two bills. I think Senator Riegle has made it clear that he is very committed to making sure that happens. Thank you. Jacqueline Dault.

STATEMENT OF JACQUELINE DAULT

Ms. DAULT. Today, I am speaking from my experience as the coordinator of the Marquette County Resident Hospitalization Program. I am employed by the Marquette County Department of Social Services. I have been the coordinator of this program for 8 years.

Firsthand, I observe the great need for medical coverage for the residents of Marquette County who are not covered by basic medical health insurance. Many who do not have medical coverage are working at low paying jobs that do not offer health care benefits. Since they are employed, they often do not meet the criteria for county hospitalization or for any other care programs.

I am going to cite one example of what I see often. A laid-off worker, age 48, was receiving unemployment benefits. He had a heart attack and was admitted to a hospital. After a period of recovery in the hospital, he was discharged and readmitted for open heart surgery. He received the care and owed the hospital and other medical providers over $25,000. Through his union, he could have continued health coverage by assuming the full premium payment, but financially he was not able to do so. He did not meet the criteria for any public health program and had to personally assume financial responsibility for his medical costs.

The last time I had contact with him, he was comtemplating bankruptcy since he would never be able to repay this large bill or afford to make monthly payments. This man had taken pride in always meeting his financial obligations and does not want to take this course of action, but feels he does not have any other choice.

No two cases are exactly the same, but this one illustrates the hardship a large group of people between the ages of 21 and 65 face that are not covered by private or public health care coverage.

Thank you for the opportunity to comment.

Ms. HUFFER. Thank you for coming. Elizabeth Junttij.

[The prepared statement of Ms. Dault follows:]

Marquette County Department of Social Services
234 West Baraga Avenue
Marquette, Michigan 49855
(906) 228-9691

Honorable Donald W. Riegle, Jr.
United States Senate
Attention: Karl P. Numinen

Dear Senator Riegle:

Today, I am speaking from my experience as the Coordinator of the Marquette County Resident Hospitalization Program.

Resident County Hospitalization is mandated by Act 280, Public Act of 1939. County Hospitalization Program is county-funded with no participation by federal sources and is utilized in situations when clients require hospitalization, but do not qualify under other programs. This program does have financial and asset eligibility criteria.

I have been the coordinator of this program for eight years. Firsthand, I observe the great need for medical coverage for the residents of Marquette County who are not covered by basis medical hospital insurance.

Michigan has excellent medical assistance programs. However, gaps in these programs leave many of the county's poorest uninsured.

Many who do not have medical coverage are working at low paying jobs that do not offer health care benefits. Since they are employed, they often do not meet the criteria for county hospitalization or for other care programs.

Most do not face catastrophic health problems because with a catastrophic illness, they would then be eligible for Medicaid. They lack access to more basic services, such as short inpatient hospitalization stays, doctor visits, prescriptions, and outpatient care.

I will cite two cases of the extreme hardship a person faces when they are admitted to a hospital and do not have health care coverage.

Laid-Off Worker

A laid-off worker, age forty-eight, was receiving unemployment benefits. He had a heart attack and was admitted to a hospital. After a period of recovery in the hospital, he was discharged and readmitted for open heart surgery. He received the care and owed the hospital and other medical providers over $25,000.00.

Through his union, he could have continued health coverage by assuming the full premium payment, but financially he was not able to do this. He did not meet the criteria for any public health programs and had to personally assume financial responsibility for his medical costs.

The last time I had contact with him, he was contemplating bankruptcy since he would never be able to repay this large bill or afford to make monthly payments.

This man has taken great pride in always meeting his financial obligations and does not want to take this course of action, but feels he does not have any other choice.

Employed Without Health Care Benefits

A woman, in her forties, employed at a local business for sixteen years was admitted to the hospital. Her place of employment did not offer health care insurance as a fringe benefit.

Since she was employed and did not meet other criteria, she was not eligible for any public health care insurance. The woman was discharged and became very depressed over her illness, personal problems, and with the additional stress of large medical bills, she took an overdose of drugs. Again, she was admitted to the hospital and was not eligible for medical assistance. This woman had to assume the financial liability of yet another hospital stay.

This woman has recovered from her illness, returned to work, and is now making monthly payments on her medical bills.

No two cases are exactly the same, but these two examples exemplify the hardship a large group of people between the ages of twenty-one and sixty-five face that are not covered by private or public health care coverage.

Thank you for the opportunity to comment on the great need for increased health care coverage. Please contact me if I can be of any further assistance in your commitment to improve care.

Sincerely,

Jacqueline Dault

Jacqueline Dault
Marquette County
Hospitalization Consultant

JD/ls

cc: file

Ms. HUFFER. Elizabeth Junttij.

STATEMENT OF ELIZABETH JUNTTIJ

Mrs. JUNTTIJ. My husband was stricken with an illness in September 1983, with an incurable illness and at that time our policy hospitalization was, like, $168 a month. Within a period of 2 years they had increased my premium to $600. I wrote to the bureau of—first of all I dealt with the insurance company and agent with no response. I wrote to the Bureau of Investigation of Regulation in Lansing twice with no response. And I just felt that I am sure that I am not the only one in this situation and wanted to state my problem because he does not have hospitalization now.

Ms. HUFFER. Because you had to give up the coverage.

Mrs. JUNTTIJ. He hasn't been working since 1983. And I just wanted to say it. Maybe it will help somebody.

Ms. HUFFER. Thank you, Sven Johnson.

STATEMENT OF SVEN JOHNSON

Mr. JOHNSON. Hi. I'll start off by telling you that you are much prettier than Senator Riegle.

Ms. HUFFER. Thank you.

Mr. JOHNSON. It is refreshing, I am glad to see that there is someone still here.

The point I wanted to make is that I have been in contact with Senator Riegle for a number of years. And I have a letter here dated March 13, 1987. I wanted everybody to know that was here but as you can see there is only a few of us here left. They now have the ear of an elected official—they are Senator Riegle's ears. And I encourage them to stay right on the track because the elected official—there are 535 in that Congress and Senate and President and Vice President. They handled supposedly all the problems that we have out here. It's a gargantuan task. It's tremendous. But there has to be a little better communication and coordination as to who these problems originate and how they originate.

So I am going to depart from some of the things I wanted to tell you. I just want to remind everybody that if you've got a problem write your congressman and believe me if you don't get a response from your congressman, write to me. My name is Sven Johnson. I have been a candidate for Congress from this district in 1982, 1984, and 1986.

The 1976 election produced a Democratic president, President Carter, you had a majority in the Senate and you had a majority in the House of Representatives. You could have written anything you wanted and passed it. But there was nothing but bickering and I mean bickering. This one heads a project over here and you had to do this negotiating. That's what they have been trying to tell me. Sven you are not getting your point across. I am going to get my point across.

The 1976 term, that's 4 years of democratic majority, I lost the best Senator that I had ever known. His name was Senator Magnusson. He had been chairman of the Appropriations Committee he was in the Senate for 36 years. He went into the Senate in 1944.

I went to work helping him in his campaigns in 1946 when I was released from the service the first time, that's after World War II. And at that time we had, I had been an employee at the Boeing Co. out in Seattle and we had our jobs guaranteed to us when we came out of the service, no problem. So when I got out of the service in late 1946 I went to the Boeing Co. There was a nice big padlock on the gate.

I am not afraid of anybody so I went to the personnel office they said, "Well, Sven, we can put you back to work but we are going to have to lay you off right away because we don't have any contracts building B17's or B29's anymore." I understand that. So quickly I went back.

Ms. HUFFER. Do you think you might address the health care issue, please?

Mr. JOHNSON. OK the health care issue. The problem has been to get the—how are we going to solve this thing. I am going to put on my glasses so that I can read this, I don't want to miss anything. I wrote it this morning.

Everybody is talking about the problem of how we are going to pay for these things. I want the Senator and all 537 elected officials in Washington, DC to know that that problem has been solved a long time ago by the U.S. Senate, the U.S. House of Representatives and the President this way. And it goes, the problem of approving the last congressional pay increase was solved by the entire Congress seating on its duff doing nothing allowing the pay increase to go into effect automatically. And it worked like a charm. Nobody did a thing did they?

Ms. HUFFER. We tried, but we were not successful.

Mr. JOHNSON. They tried but they waited until after the 30 days was up. That's when they tried. See but after the 30 days was up it was automatic. No matter what they tried they got the pay increase.

So I will continue. My suggestion is why don't you write the same kind of solution into law only this time in reverse that says that if the Congress doesn't act to raise the debt limit within 30 days that there can be no increase in cost for anything that Government has to pay for. It's just the opposite. If the Congress doesn't act, at that point nothing will increase. When they didn't act they raised their wages automatically. Make it in reverse. That kind of law providing Congress did nothing for 30 days raised congressional salaries from $77,000 to $99,000 a year. So what I am saying is, write that law in reverse that nothing can increase in cost unless Congress acts within 30 days to legislate an increase whether it is for health care, to buy a house, just a minute.

Mr. NUMINEN. We just want to remind you we do have some more people who want to speak.

Mr. JOHNSON. Oh, I know I have been here since early this morning when Senator Riegle was saying good morning this afternoon. I will be through in a hurry. To legislate an increase whether it is for health care, to buy a house, a sack of potatoes, a television, a gallon of gasoline you name it. That law worked to increase congressional salaries. In reverse it should work to prevent catastrophic health costs.

Senator Riegle I am certain you will recall our 1986 meeting in Newbury. I will remark on that right now. I went to Senator Riegle in 1986 primary and I advised him that we had to get the Senate majority back in the 1986 election or Senator Riegle wouldn't be here holding this meeting because you would have a Republican chairman and it wouldn't be here. Now this meeting is because of the work that these people did to get democratic majority elected back into the Senate. That's in—and I was instrumental in that because of the people I reversed in the State of Washington to get Mr. Brock Adams elected. You lost Senator Slade Gorton. No loss. I just wanted you to know why this meeting is and why Senator Riegle is here. You know we have done our work to get him here and I have informed him that 1988 is the important election.

Mr. NUMINEN. Let's wrap it up, Marian Guelff would like to speak.

Mr. JOHNSON. So, with the Senate and House majority in this 100th Congress, what is the problem in writing such a law. Think about it this way—this administration is saying that they have curbed the inflation rate to under 4 percent per year at the same time that the national deficit has gone from $1 trillion in 1981 to $2.2 trillion by 1986. To me that amounts to more than a 100 percent increase in the deficit. Actually 120 percent. Who's kidding who about catastrophic costs in anything that the average American citizen has to pay for including congressional salaries.

Ms. HUFFER. Thank you. Marian. Thank you all who are still here for being patient and for sticking with us. Your testimony is important.

STATEMENT OF MARIAN GUELFF

Ms. GUELFF. My name is Marian Guelff. I am a medical social worker and director of social services at a small rural hospital in Marquette County.

I would like to address some of the issues of medicare from someone who is working with them on a daily basis from the inside. I think the medicare system is labored with misunderstandings by the general public as to how it actually works and puts together when someone is really sick. I have heard today many misconceptions about the system and as to how it really is working. I would like to address some of those. This may take a few minutes but maybe it will be helpful in the long run.

Is health care really a right? Is our government saying that? OK if it is, then some of the teeth have to be put into law to make it truly effective for Mr. and Mrs. Jones, U.S.A. OK. We need to have a cap for eligibility for medicare similar as it is to medicaid. If your retirement income is x thousand dollars or more per year, you are what we might consider self insured. You would not need medicare. Medicare is an insurance program. Medicaid is an assistance program. There is much confusion about these two programs throughout the general population. I run into it on a daily basis. I am constantly being put in a position of having to explain again and again and again, over and over for people. They do not seem to understand.

Some of the simple things that could be done from the eyes of an insider working with this. There was much discussion today about having to send nursing home people away from their local home communities. All medicare has to do is say yes, we will pay for a basic level of care patient to remain in a hospital until a nursing home bed in their own community is available. That's a very simple thing that medicare can do. Another simple thing that medicare can do is say to the individual States, we pay you so much contributing dollars toward your medicaid programs. You eliminate your certificate of needs system within your States. Let private industry take care of itself, and let people build nursing homes where they think they are needed. The competition is good. If you want to buy a pair of shoes you go into the shoe store next door to a shoe store. And I think it's the same thing with nursing homes. The competition would be healthy. It would provide for higher and better level of care in nursing homes. Nursing homes can practically write their own ticket in the Upper Peninsula and it's unfortunate. It truly is.

The only way a person can buy themselves any choice at all into the nursing home that they want to go to is with their pocket book. Many of our patients opt to pay private pay and remain in the hospital until a nursing home bed is available.

Another thing I listened to a lot today is about personal care and attendant type services needed not only for elderly but for the younger disabled. This is another thing that I see very simply handled through medicare is on your one sheet print out here is you have the new provision under home health care. Just simply add under there that home health care will provide for basic services, they will pay for basic services, not just skilled services but for basic services which would include your attendant care types of things. Keep these people at home. Don't make them wait so long that their situation becomes catastrophic and then has to be paid through disability Medicare at a triple rate in the hospital. Let's practice some preventive kinds of things, OK. These are my main concerns.

The purpose of a nursing home is for rehabilitation, for the long term care of rehabilitation of patients. We are denying patients—if we are going to call it right, if health care is a right—then we are denying them that right to that by the current policies. I guess that's about all I have to say.

Ms. HUFFER. Thanks for your contribution. Max Engel.

STATEMENT OF MAX ENGEL

Mr. ENGEL. Well, I have a prepared statement here that I am not going to go into but I have some additions to it.

Ms. HUFFER. You can leave that with us and we will make sure it goes into the record.

Mr. ENGEL. When I was sitting here listening to everybody today, a lot of things came to mind. And I think an important point to make is that even with national health care, that isn't an answer to the entire problem. With a national health care system you would still end up with the same problem you have with medicare and medicaid. As more payments are made doctors raise their fees

and then the expenses get too high for the national program to work. Other legislation has to be done at the same time as the national health care to help curb physicians fees.

One thing that is in my statement here is about a small incident with my own son. He had an accident, had some minor out-patient surgery. For 1 hour in surgery, the doctor charged $1,500. I wish I could get paid that much. That did not include the hospital bill, any of the drugs, any of the nurses. That was all extra on top of that. The doctor himself gets that amount. The problem is that many of the fees that the doctors are charging today are very unreasonable. Health insurances realize that and try to do something about it by putting usual and reasonable fees on their bills. But the problem with that is that the only thing that does is shift the payment to the individual or raise insurance fees where they become totally unreasonable also. Something needs to be done and we need massive legislation to try to curb the rise in health care. Many of the hospitals have such legislation, or at least some legislation to stop that. But the doctors raise their fees anytime they want and with that you can have this statement, and thank you.

Ms. HUFFER. Thank you.

[The prepared statement of Mr. Engle follows:]

PREPARED STATEMENT OF MAX L. ENGLE

My name is Max Engle I am a resident of Chocolay Township in Marquette County. I am a representative of the Communication Workers of America, Vice President of Marquette County Labor Council and Vice Chair or the Upper Peninsula Blue Cross Blue Shield Advisory Counsel.

I feel our Federal and State Legislators are failing in their jobs in respect to health care. We regulate telephone service to ensure good service and affordable rates, We regulate the electric company and the gas company. Yet when it comes to out health care it is left up to who can afford it. I am sure that the laws we have now are a throw back to when the doctor was an intricial part of the community traveling from house to house doing surgery on the kitchen table, believing in his hippocratic Oath and receiving pigs and chickens for payment. this is no longer the case, being a doctor is BIG business making big bucks and the question when you walk in the door is how soon can you pay us or payment is expected before you leave.

People complain about their phone bill at 9-10 Dollars a month and consumer advocacy groups attack the phone, gas, and electric companies when they ask for a rate increase. Yet physicians raise their prices and no one does anything about it. I do not begrudge any

physician a good income I feel they deserve it but the costs are getting to high, It is getting so that only a select few can get the type of health care everyone deserves. Most hospitals are regulated enough but physician charges have skyrocketed.

Recently my son had an accident on his bike, it was a rather serious accident he spent 6 days in the hospital and had 6 different doctors take a look at him. One doctor charged $181 dollars for an emergency room consult (approximately 10 min) And $36 dollars for each 5 min visit the other days. Then for a follow up, an office visit for 10 min $42 dollars. I have not received bills from the other doctors yet. These bills are unreasonable and my insurance company felt so also. But I have no recourse but to pay the doctor out of my own pocket. When you are in that type of situations you don't have a choice of Being able to ask(can you give me an estimate of what this will cost) and in areas like the U.P., even if you could, you still only have one physician to chose from.

Maryland has passed some laws recently to help slow the rise in physician fees. One doesn't allow a doctor to charge over what Blue Cross Blue Shield recognizes as a reasonable and customary charge. Michigan however passes laws making Blue Cross responsible for keeping physician costs down but doesn't give them any authority or any means to force the physicians to lower their costs.

HMOs and PPOs help reduce cost but in areas like the U.P. the physicians have such a strangle hold that it is

nearly impossible to get one formed.

Something needs to be done to reduce health care costs now, whether on a state or federal level. But to make things uniform a federal level would be better. Changing the amount medicare medicaid and other insurance pays doesn't reduce the problem, all it does is shift the burden from companies to the individual. My insurance is supposed to cover 90% of my physician bills and ends up covering 60-70%. One of my friends had open heart surgery after insurance paid all it was going to he ended up with $5000 dollars in unpaid bills. He was paying these off on a monthly basis when one of the physicians turned him over to a collection agency.

Business is crying at the bargaining table about the high cost of health insurance and health care. Most contracts in the last few years have shifted health care costs from the companies to individuals and many plans have been devised to bring these costs down but nearly all reduce the cost to the company and raise the employee cost. This does not help the problem it only aggravates it.

Legislation needs to be passed to control fees. Every person in the United States is entitled to good health care which is fast becoming the exception rather than the rule.

Max L. Engle

Max L Engle
380 Karen Rd
Marquette,Mi 49855

Ms. HUFFER. Is there anyone else in the audience who wishes to speak. Please.

STATEMENT OF LAWRENCE RUBIN

Mr. RUBIN. My name is Lawrence Rubin. I am chairman of the board of the Mackinac Straits Hospital and Care Center in St. Ignus. It's a small hospital but there are those of us who love it.

There are two points of a practical nature I would like to address and then one of a philosophical nature. First, we have on our board an accountant, CPA, a lawyer, and I who have had some experience with financing, particularly the Mackinac Bridge and the Sault Ste. Marie International Bridge. And yet none of us are able to grasp the financial aberrations of medicare, medicaid and all the other rules and regulations. And I wish somebody in Washington—I know they have the brains down there—would figure out a rather simple process whereby members of the board can look at a bottom line and understand what is means. Sounds silly in view of all the testimony that we've heard today but it is important to those of us who operate care facilities.

Second, I would like to address the point of being penalized for operating efficiently. If we save money in our operation, our payments are reduced. And this is kind of difficult when you're trying to lay up a nest egg in case you have to buy a new X-ray machine or some other expensive equipment which you can't anticipate. So perhaps the Senator can do something in addressing that problem.

Finally, of a philosophical nature, I'm tremendously impressed with what happened today. Over 300 persons from this sparsely populated but beautiful area assembled here. In an outpouring of emotion that I've never heard before, baring their souls and lives to the Senator for something that is so meaningful and important to them. And I would submit that since this hearing is held in an area that represents less than 0.4 percent of the population of this State, that somebody better perk up their ears and listen. Because if we extrapolate this hearing to the rest of Michigan, there will be no hall big enough, no stadium big enough, to take care of all of the people who have something to say about this problem, this matter of catastrophic care. I don't like the word "insurance", I don't like the word "catastrophic", I like the word "humane". And I think that it is uncaring, it is uncivilized, it is inhuman and totally disgusting that the idea, the concept that in this country of great wealth, we allow ourselves to treat God's own creatures, human beings, to suffer all sorts of pain, indignity, psychological torture, because of money. Somewhere along the line our priorities have been misguided. And I think, when I hear about these things how many bombers does it take to cure cancer?

In closing, since I am the last speaker, I would like to thank the Senator for conducting this hearing. I trust he will use his influence, past, present and future, in convincing his colleagues that something must be done about it. Thank you very much. [Applause.]

Ms. HUFFER. Thank you for that eloquent note to end the hearing on. Anyone else? This meeting is adjourned.

[Additional material for the record follows:]

A M F
ACOCKS MEDICAL FACILITY

ACOCKS DRIVE ● P.O. BOX 160 ● MARQUETTE MI 49855

August 28, 1987

Marquette County Board
of Social Services

RONALD KEEFE
Chairperson

BETTY HOWE
Vice Chairperson

JOHN ASHBY
Board Member

HARRY G. SCOTT
Administrator
906/226-3586

Senator Donald W. Riegle, Jr.
323 Federal Building
Marquette, Michigan 49855

Senator Riegle:

Please give consideration to this written testimony relevant to today's Senate hearing to be held at Northern Michigan University that focuses on health care issues.

Long-term care illnesses, whether a patient is maintained at home or in an institutionalized setting, are out of sight for even the high-wage earners, and lifetime savings are eradicated for some immediately, for some within a few years. This testimony is aimed specifically for institutionalized patients, the vast majority of whom come into this facility already "indigent" and dependent on the State and Federal programs to cover their expenses.

1. When illness necessitates hospitalization, there are currently no funds available to those patients for "bed holding." When a person has had to forfeit a lifetime of saving, when they have had to plunge into poverty because health-care costs are so outrageous, so financially crippling, that person should have some reassurance that their final days will be spent in one familar place. In order to assure that all recipients are provided the opportunity to return to the facility they have resided at, it would seem the onus is on the health-care funding program to make allowance that coverage will be available to the facility to defray the cost of holding that bed.

2. More funds for equipment for those patients residing in long-term care facilities. Individual ownership of equipment may be the last semblence of worldly possession for those persons who have had to give up homes, pets, the security of a bank account, mobility, and numerous other losses. Facilities are required to make available a certain amount of equipment to residents, however, this becomes community property which contributes to an atmosphere of institutionalization--for example: if a facility has four obese residents and only three oversized wheelchairs to accomodate the extra weight, one of those residents will not be able to be up and participating in the activities of the day, or for a portion of the day--to that person, left behind, the emotional impact leads to withdrawal and eventual mentation decline--unnecessarily. Hygienically, there is an advantage to each person having individual equipment as well.

3. Make available dentures. On a purely social/emotional level, food is known to be one of the final remaining pleasures. Institutionalized people are bound to eat the nutritionally and calorically approrpiate diets developed to meet their special needs; considering the amount of "regulation" surrounding this old-age pleasure of eating, it would seem these old people are entitled to have teeth (in the form of dentures) in their mouths in order to chew and enjoy the meals they are provided with. There is no visual pleasure in ground and pureed food. Yet, the program in effect today operates on the principal that a person near death would not benefit from replacement/repair of dentures, or that somehow if one is confused they do not need dentures. All people, especially those elderly, are entitled to good dental condition and this needs to be provided via long-term care insurance (Medicaid) for the impoverished.

4. Currently, Medicaid allows a person a "Personal Needs Allowance" of $28 per month, the rest of their income (ie: Social Security, pensions, etc.) must help pay for their long-term costs. Twenty-eight dollars per month does not cover personal needs. Without allowing personal opinions to influence, consider that a person who is a relatively heavy smoker will not be able to buy cigarettes as well as have money for a haircut and lunch out or buying gifts for others (ie: grandchildren, etc.). People in facilities need more than $28 a month for personal needs.

Although I have a great many concerns about long-term care residents, the above outlined are those which seem to be most pressing. Any consideration you can give to these issues when developing the budget will certainly have long-term benefit for those elders who should be revered for their longevity, and ultimately for society as well. We must show society that we consider our elders a valuable asset, worthy of a fair, comfortable standard of living, and not relegated to the ranks of the indigent poor by virtue of being old and ill.

Thank you for this opportunity of being heard.

Sincerely,

Linda Knight

Linda Knight, B.S.W.

A.D. Alzheimer's Disease
and Related Disorders Association, Inc.
17321 W. Twelve Mile Road • Suite 108 • Southfield, Michigan 48076 (313) 557-0977

Senator Donald Riegle's
Senate Hearing on Health
Care for Catastrophic
Illness and Long Term Care
Allen Park Municipal Bldg

July 27, 1987

TESTIMONY FROM: Jill Houle
14418 Park
Livonia, Mich 48154

Thank you, Senator Riegle, and members of the Senate Finance Committee for this opportunity to be with you today. I want to share with you and other members of the Committee a synopsis of the financial plight of families who are caretaking for a chronically ill or demented patient or who are facing the prospects of financial devastation to pay for such care.

My father has been diagnosed as having Alzheimer's disease. It has taken quite a while for my mother to face the reality of the disease and the reality that she could not care for my father by herself. The personal trauma of such a disease is unique. The generalized horror stories in terms of memory loss, behavioral problems, wanderings, disorientation are what you have heard before.

An array of support services is critical if families are to be able to continue home care as long as possible. A vast majority of families try to maintain care at home. It is more humane and less expensive for all concerned.

The growing number of elderly and lifestyle changes that have taken many female family members into the work force will dramatically reduce home services. There is, too, going to be a rightful reluctance of spouses and children to become impoverished to meet the needs of an Alzheimer's disease or other chronically ill patient. It is in society's interest to find options for these growing numbers.

My parents have been luckier than most. Their monthly income, about $1,250, allowed them to live the middle income lifestyle my father's job allowed them to achieve. They paid for a modest home in the suburbs and built a modest nestegg which they fully expected would serve them well in Dad's retirement years. And it did, until Dad's Alzheimer's disease

reached a point where Mom could not care for him by herself without seriously jeopardizing her own health which is in itself quite fragile.

Our first effort, to bring in a home aide a few days a week, averaged $250/week or over $1,000/month. Since my parents' combined income from pension, Social Security and savings interest simply allowed them to meet on-going, routine expenses, they had to start dipping into their savings. Since Dad's needs were more custodial than medical, they were not covered by Medicare.

We cared for Dad at home as long as physically, emotionally and humanly possible, a year after his problems became totally unmanageable. As a last resort, we placed Dad in a nursing home. The problems there were two-fold; quality of care and financial.

The initial rate under which Dad entered the home was $53/day. Three days later the rate was raised to $59/day. The reason given was a $3/day charge each for a special diet and for incontinence. To our knowledge, Dad had no medical problem requiring a special diet and had not been incontinent prior to admission. The nursing home's practice of physically restraining him in a wheelchair may have prevented his use of bathroom facilities and been a reason for his incontinence.

Three months after admission another $14/day was added to the daily rate, bringing it to $73/day. A new $12/day charge was for "confusion". The $3/day incontinence fee was raised to $5/day. A short time after that, nursing home officials informed me the rate would increase again, this time by $100/day as a "combative charge." This was to be added just days after nursing officials at the home raved about how well Dad was doing.

Other outrageous charges such as $3/day to help Dad cut up his food and eat, and a 40% mark-up on prescription drugs made it imperative that we find a new home for Dad. The original price we had been quoted for care had risen by almost 50% in less than three months. A typical bill was about $2,500/month, causing a much quicker erosion of my parent's savings.

Medicare may have paid for some of Dad's care. Our efforts to determine that have been unsuccessful. Medicare has never even issued a denial of claims submitted nor have any of our calls to the number given for assistance been returned. Federally, we're in a state of limbo.

Dad is now in another nursing home where the bill is closer to the original price quoted by home number one. Even at this reduced rate, I estimate that my parents' entire savings will last only about one more year, two years in all. At that point, it is doubtful that my mother will be able to maintain her home, and meet her basic needs and still pay for my father's care. Should my father pre-decease my mother, her financial plight will be excerbated. Not only will she have used her savings to pay for Dad's care, but with his death her income

will be cut by two-thirds. She will no longer have his Social Security benefits to rely on, and his pension stops with his death. Who will help pay for my mother's care?

Before I close, let me raise other issues that this Committee and others dealing with long term care should consider:

1) The continuation of nursing homes requiring private pay before a patient's eligibility for Medicaid can be exercised.

2) The "bait and switch" tactics on the cost of Nursing Home care that I truly believe home number one and others like it practice.

3) The licensing requirements of a nursing home to meet routine care needs basic to their existence. The population of nursing homes is physically fragile and care is needed with daily activities of eating, personal hygiene and toileting. There should not be extra charges for routine, licensed services.

4) The return to the drugging of patients to control them, a practice that should never have existed, but that I thought went out of vogue several years ago. This seemed to be the practice at home number one.

My parents came of age in the Depression. They saved to provide for their old age, an old age which they thought they would enjoy together and which would justify their years of denial, scrimping and saving. They are not being rewarded. The same society that praises thrift is now punishing my mother for that same trait.

My mother deserves better. So do millions of men, women, spouses, sons and daughters. You will undoubtedly be hearing from more of them as their numbers grow. Hopefully, the Senate under your leadership and that of this Committee will take positive action to assist those voices and the impoverished families they represent.

Bushnell, Gage, Reizen & Patton

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July 20, 1987

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ATTENTION: Ken Payne

Senator Donald Riegle
109 W. Michigan Avenue, Ste. 705
Lansing, Michigan 48933

Re: Allen Kaminsky
Forum on the Uninsured and Underinsured in Michigan

Dear Ken:

Pursuant to your request, Allen Kaminsky came to our offices to discuss his testimony regarding Senator Riegle's forum on the Uninsured and Underinsured in Michigan. His testimony will consist basically of the following:

Allen can trace his multiple sclerosis symptoms back to the early 1970's when he began experiencing blurred vision in his left eye and loss of balance while engaging in sporting events such as baseball, basketball and tennis. In 1980-81, Allen was diagnosed as having multiple sclerosis. At the time he was diagnosed, Allen was employed as a salesperson for a major dental supplies and equipment company. His employer provided him with a medical insurance plan which covered one hundred (100%) percent of his hospitalization stays, which were infrequent at best, and covered eighty (80%) percent of the cost of his prescriptions.

In November, 1984, Allen admitted himself to Mt. Carmel Mercy Hospital for the purpose of receiving ACTH (a steroid) treatment for his multiple sclerosis symptomatology. He was expected to be hospitalized for approximately 7-10 days and then to recouperate at home for an additional 10-14 days. Nevertheless, while he was in the hospital, his employer sent him a letter advising him that

he would be placed on a one (1) year medical leave of absence without pay. His employer permitted him to continue his insurance coverage provided that he pay bi-weekly out of his own pocket for the same.

Prior to being placed on this one (1) year leave of absence, Allen required no adaptive aids or devices as a result of his handicap. However, as time passed and the stress of being placed on this one (1) year leave of absence without pay took its effect upon him, Allen's multiple sclerosis symptomatology exacerbated to the point where he in fact did need certain adaptive aids and devices to assist him. Specifically, Allen required certain modifications or changes in his home to make it handicap accessible. Specifically, Allen required grab bars in the bathroom, a special shower seat, a wheel chair and a walking cane. Allen's insurance company refused to pay for such items and the State of Michigan refused to assist him as well.

Thereafter, Allen contacted the Commission for the Blind. The Commission generously offered to assist Allen and put the grab bars and shower seat into his bathroom and obtained a Premier Wheel Chair for him. Once Allen received the wheel chair, however, he was unable to get the wheel chair into his home--a ramp was required. Once again, his insurance company and the State of Michigan refused to assist him. Accordingly, he contacted the mason's, or members of the Masonic Temple, seeking their assistance in building a ramp for his home. The masons volunteered their services and did in fact build a ramp for Allen.

At the present time, Allen maintains Blue Cross or Health Care Net Work, coverage for himself and his family. He pays Two Hundred Four ($204.00) Dollars per month for the family in order to maintain such coverage. Additionally, he pays Eighteen ($18.00) Dollars per month for Medicare. His present insurance does not cover prescriptions, equipment, or physical therapy treatments. This is significant in that the cost of his prescriptions can accumulate significantly over time as a result of his multiple sclerosis. Additionally, physical therapy treatments are expensive and cannot be afforded without insurance coverage. Finally, he is required to pay Ten ($10.00) Dollars per doctor's visit per member of his family. While this may not seem to be a significant dollar amount, it is significant to an

Bushnell, Gage Doctoroff & Reisen

individual who has been terminated from his employment and is supporting a family.

We hope that this brief summarization has been helpful to you. I look forward to hearing from you and until then, I remain,

Very truly yours,

BUSHNELL, GAGE, REIZEN & PATTON

Ivy O. Giller

IOG/eml

CAA Community Action Agency
& Human Resources Authority
507 First Avenue North • Escanaba, Michigan 49829 • (906) 786-7080

Lorraine Shiner, Executive Director
Lloyd Benson, Chairperson

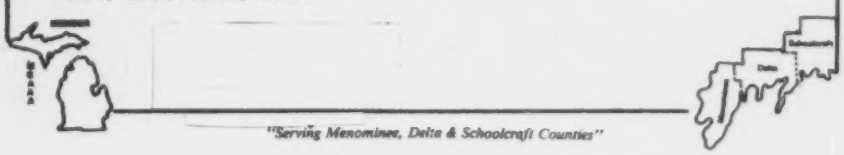
We are happy to see several bills addressing health care for our elderly and would ask that consideration be given to the following. HB4648 to consider nursing home emergencies admissions in their pre-admission screening.

HB4456 and/or 4459 to address the discouragement of nursing homes accepting only a percentage of medicaid patients. There are presently 1,000 elderly on the waiting list in the U.P. to enter nursing homes, yet an application to build a nursing home in the Escanaba area was turned down. The reason given was there are already too many nurseing homes.

Mean while our elderly are suffering. We through the CAA Senior Citizen Centers do what we can with the little we have, such as home makers who get a meager 10 hours per week and care for 8 to 10 Seniors giving them one to 2 hours a week, home delivered nutrition meals and transportation to Doctors for the seniors who can get out and what ever other service our Senior Center funds allow. Because of liability we are not allowed to give personal care such as bathing or washing hair. Due to a shortage of funding we cannot reach the outer areas of the counties.

Our seniors, deserve to be taken care of properly. They worked hard building our country for meager wages and deserve to be taken better care of.

Medicare insurance should cover such necessities as nursing homes, and prescriptions.



We have senior citizens who at 100 years of age can and want to remain in their homes.

We have seniors who at 70 - 80 etc., due to very poor health problems, such as heart, strokes etc. cannot even do the basic care such as feeding or personal CARE. They under and over medicate themselves. Many cannot afford even generic medicines. They deserve to live in dignity and with a minimum of suffering

We need your help to help our Senior Citizens.

Thank You
Leona St Vincent

STATEMENT OF DAVID CUNEO, PRESIDENT, HHS, INC.

My name is David Cuneo and I am the President of HHS, Inc. HHS, Inc. is a unique joint venture between area business, the Junior League of Grand Rapids and the Area Agency on Aging of Western Michigan. We offer health care management and cost containment services to area employers and provide a care management service to the frail elderly who are either in nursing homes and have a desire to return to the community or are in danger of premature nursing home placement.

In our capacity as a health care case management organization for all age groups and, for both the private and public sectors, we have directly observed the devastating effect of catastrophic and long-term illness on both the elderly and younger age groups.

We have often observed families struggle with the financial impact of long-term care illness--an area that this society has not chosen to address, leaving the financial burden often on those who can affort it the least--the elderly.

Recent efforts in Congress to address catastrophic health care are welcomed and address the increased costs that retirees must pay for acute care coverage, but it actually will do little to address chronic long-term care illness--specifically home care, nursing home care and expensive prescription drugs.

In fact, efforts such as House Bill 2470 will have an impact on relatively few individuals who do not have medigap supplemental insurance policies. In addition, with the new DRG prospective payment system, fewer elderly are staying in the hospital for long periods and using up their Medicare reserve days. The elderly are being moved out of the hospitals much sooner than before, but little has been done to address their care needs as they go home "quicker and sicker". I do be-

lieve that we need to stop the deterioration of Medicare. Many older persons are finding it difficult to afford their medigap policies as government reduces what Medicare will pay through increased deductibles and co-pays.. In addition, many employers that have provided their retirees medigap coverage in the past are now rethinking that commitment for future retirees as government increases their cost and as the employers' ranks of retirees swell as people are living longer.

What really needs to be addressed is the chronic long-term care needs of the frail elderly. Many older persons have had the false impression that Medicare would take care of the long-term care needs, including nursing home care. Many are shocked and find it hard to believe that they only have coverage for acute care and that once they are out of a hospital setting they are pretty much on their own for their long-term care needs--at least until they have spent themselves into poverty and they become eligible for Medicaid.

What is really needed is an initiative that will stop the deterioration of Medicare and also address the long-term care needs of the frail elderly. Currently the only assistance to address long-term care is Medicaid which has two main flows. First, it forces people into poverty and second, it will only pay for basic care if the person is in a nursing home.

What is needed is a program that will ease the financial burden on the elderly and their families. It must be a balanced approach that focuses on home care as well as nursing home care. It must also protect the assets for the spouse so that all assets are not expended for long-term care needs of one person leaving the spouse to live out their life in poverty.

We must recognize that many people are reaching retirement in good financial shape. More people are planning for retirement and many more are now receiving pensions and have savings to supplement their social security. Very often we see clients who have done a reasonable job of planning for old age only to have a catastrophic illness wipe out their savings and exceed their current income. For example, we recently handled a case that involved an 86 year old woman that I will

call Mrs. H. Mrs. H. had a stroke in 1986. Her 87 year old husband took her home from a nursing home in June of 1986. Initially, Medicare paid for an RN to visit one time per week and a home health aide twice a week. Mr. H. paid a home care agency to provide needed care for three hours per day on the five days not covered by Medicare. Medicare coverage ended in six weeks and all needed care had to be paid by Mr. H. At the time Mrs. H. went home, they had $22,000 in savings and received a combined income of $841 per month. In addition to paying for the home health aide, they also had to pay for seven different medications, a special liquid food supplement and other medical bills not covered by Medicare. Through careful money management, Mr. H. was able to care for Mrs. H. for one year at home, but now the savings are gone and Mr. H., at 87, can no longer provide the care she needs or afford to pay for it from an outside source. His only recourse was to admit her to a nurisng home where her expenses will be picked up by Medicaid. Now with his savings spent and Mrs. H's social security going toward her nursing home care. Mr. H. lives in poverty, barely able to meet expenses.

A better scenario would have been a program that would have assisted Mr. H. to provide the long-term care needs of Mrs. H. in their home. Mr. H. was able to care for Mrs. H. with the assistance of a home health aide for three hours per day. It was only after Mr. H. could not afford the home health aide and the medications that he was forced to admit Mrs. H. to a nursing home. Now government, through Medicaid, is paying for all of Mrs. H's care in the nurisng home at a much greater cost.

What is needed is a comprehensive long-term care program that focuses on home care. We need to focus our efforts in supporting the family and informal support network through case management and a strong home care network that will ease the financial burden of our older population. We also need to insure that government support does not focus only on nursing home care as it has under Medicaid. Currently there are many elderly, often estimated as high as 30%, that are in nursing home but do not require that level of service. Any expansion of nursing home pay-

ment should include a nursing home prescreening process that will have the capacity to prevent unnecessary nursing home placement and have case management capacity to assist individuals receive the community services that would enable them to remain in their own homes.

I want to thank you for the opportunity to address this very important issue and want to offer any assistance I or my office can provide in developing solutions to the long-term care needs of our elderly.

STATEMENT OF MARGARET KORONKIEWICZ, GRAND RAPIDS, MI

Senator Riegle, my name is Margaret Koronkiewicz, and I am here to testify on behalf of my mother.

My mother has been alone for the last 4½ years, since her second husband died. Since she was at home alone, there had been no one to monitor her health. Over the past several years, she has developed crippling, but not life-threatening disorder called osteoporosis, also known as dowager's back. Mother tried to keep this from us, although we now know that she had been falling down and becoming unable to take care of herself. When we found out how serious her condition was, we started to arrange for her to have home help. When we went to her home to arrange the final details, we found that the condition was so severe that we took her to the hospital, and then to a nursing home. Now, she is totally helpless; she can't stand up, can't walk, can't take a bath, and needs assistance to use the restroom.

Needless to say, the nursing home she stays in is very expensive. It costs $54/day, and when you add in the cost for prescription drugs the cost comes to about $1,800/month. Now my mother over the course of her life had built up a fund for her retirement, she had paid for her home, and thought she was going to be able to make it on her own. Now, after only 10 months in the nursing home, about half of the $35,000 she had saved will be gone. Her whole life savings will have been wiped out in just a year and a half. She will be forced to go on Medicaid and be totally reliant on the state. Although

Medicaid will allow her to keep her home, the property taxes, insurance, and upkeep are very expensive. If she is forced to sell the home, she must spend all of the assets derived from the sale on the nursing home in order to re-qualify for Medicaid. Medicaid also allows her to keep $2,000 in a burial fund. This is an unrealistic figure if you look around at the costs here in Grand Rapids.

Senator, I think that my mother's situation makes it clear that the Congress should include coverage for long-term and nursing home care in the Medicare system. Otherwise, people who work hard and save all their lives are penalized for their work by having to watch their life's savings be used up so quickly.

STATEMENT OF MELINDA LARSON, GRAND RAPIDS, MI

Senator Riegle, I am here today to testify about the very high cost of prescription drugs and the need to include coverage for prescription drugs in a catastrophic health care bill. I am 73 years old, my health is deteriorating, and I am finding that prescription drugs are so expensive that they are taking a large percentage of my social security check every month, leaving me with little to live on. My husband and I worked all of our lives to build up the little we have; we paid for our home, and had a small bank account for our retirement. With our social security, we had enough money to live on, albeit modestly. Then, about 10 years ago, my health started to go bad. I developed chronic bronchial asthma, diabetes, heart trouble, and arthritis. Because Medicare wouldn't begin to cover the bills associated with these problems, I needed to supplement my Medicare with Blue Cross at a cost of $43/month. Even Blue Cross does not cover my medication. I need medicine for my asthma, insulin for my diabetes, and pain relief for my arthritis. In addition, I need oxygen. I was given a machine that makes oxygen, but the electricity to run the machine costs about $30/month. The total cost of these medicines, oxygen, and my Blue Cross supplemental is about $230/month. That may not sound like a lot of money, but with my husband's pension and our social security, our total monthly income is less than $950/month. That leaves us with only $700/month to live on, and taxes and insurance take a large chunk of that every month.

Although prescription drugs are our largest problem, we do have others. Our main problem is the need for in-home nursing. I was in the hospital in January, and after I got out, Medicare paid for a home nurse. About three weeks ago, I learned that Medicare would no longer pay for an in home nurse except for one visit per month. In addition, they will pay for bathing once per week. Another concern I have regards hospital stay. In January, when I was in the hospital, I could only stay in each hospital two weeks, because that's all that Medicare would cover. How can we be sure when we are discharged from the hospital that we are being discharged when we should be and not when Medicare says that they will no longer pay? I am particularly concerned about this as I have recently developed kidney trouble. I am not sure whether this will result in hospitalization, or in yet higher prescription drug bills.

MARY FREE BED HOSPITAL AND REHABILITATION CENTER
235 Wealthy St. S.E., Grand Rapids, MI 49503 Phone (616) 242-0300

August 11, 1987

Senator Riegle:

I am happy to be speaking to you today about my concerns about the lack of adequacy in the Medicare Health Coverage Program. Mary Free Bed Hospital and Rehabilitation Center is an 80 bed free standing rehabilitation facility in Grand Rapids, Michigan. It admits and treats patients with the diagnoses of CVA or stroke, spinal cord injury, head trauma, and has a pediatric wing. Patients come to Mary Free Bed after a stay in an acute care hospital. In other words, we are not the initial site of treatment after a medical incident or an accident.

Initial insurance coverages are used at the acute care hospital. Mary Free Bed quite often gets into more extended coverage. We note the following problems:

1) Many Medicare recipients do not elect to take Part B and do not have supplemental insurance coverage.
2) Ambulance coverage is inadequate.
3) The amount of home care is limited.
4) Where home care is granted, the recovery guidelines are those of a rehabilitation level which indicates a greater line of recovery. Often a patient is making progress and needs continued therapy to become independent in a home situation but the benefit does not last long enough to maximize recovery potential.
5) The amount of nursing home coverage is inadequate. Older persons who have suffered a trauma need sufficient time to become medically healed and then go through rehabilitation types of efforts. They do not necessarily recover as fast as a young person.
6) Medications are not covered. Supplies and medications can run to a great deal of money.

7) The equipment provision is woefully inadequate. Only the most basic kind of wheelchair is allowed. Equipment which can make a lot of difference in terms of functioning at home is considered "safety" equipment and will not be funded. I'm speaking of items such as a transfer tub seat, raised toilet seat and versaframes. They minimize the risk of harm in the bathroom, are not costly and are not covered.

8) Even if a person has supplemental insurance, it only comes up to what Medicare screens allow.

You need not think that the stroke population is the only one which encompasses Medicare recipients. There are Medicare recipients in the closed head injury population and we have seen significant numbers in the spinal cord population, coming as a result of fall or accident.

Another consideration is that Mary Free Bed has only 80 beds and must weigh their admissions quite carefully. Our criteria for admission are medical rehabilitation goals and discharge planning. When we see an older person who does not have a significant other in the home to provide some care, and the coverage is Medicare only, we must very carefully assess how much care they will require and see if there is any way to achieve a discharge plan.

In spite of all these dark predictions, we are still sending 80% of our patients home, but we are forced to scrutinize those patients who receive rehabilitation services much more carefully.

Finally, you need to consider the needs of younger people who become catastrophically disabled. Those young people are not going to go back to work and may come on to the Social Security rolls through the SSI system. Many of them have worked for some time, but there is no potential to return to work as they are permanently disabled. The insurance coverage and protection here is very, very inadequate. Equipment funding, and particularly home care and attendant care needs are not addressed by public insurances. We are forcing citizens into nursing homes who could live quite productive lives and certainly have better quality lives in their own home.

Thank you for the opportunity to come and make some remarks to you today.

Kate Lynn

STATEMENT OF MAXINE POTTS, HOLLAND, MI

Senator Riegle, my name is Maxine Potts. I came from Holland this morning to testify to the need to change the Medicare system to cover the cost of medical bills for catastrophic and long-term illnesses. I have two long-term illnesses, and I know from personal experience that Medicare just doesn't do enough to pay the medical bills I have. When I was 33, I was diagnosed with Lupus and a rare form of Muscular Dystrophy. These are very crippling diseases. My medical expenses so far this year have exceeded $20,000. In order to even come close to covering these bills, I have to supplement my Medicare with Blue Cross. Even so, I pay out of pocket every year about $2,500 per year, or about $200 per month. In addition, my Blue Cross bill is $45 per month. That's a total of about $250 per month, and my total income is $501 per month from social security. That means I must pay all my personal expenses with just $250 per month. That includes $97 for rent and $25 for my phone (which my doctor insists I have). Now my doctor has prescribed drugs for my condition. These drugs cost about $80 per month. If I bought these drugs, I would have no money left over to buy food! I just don't think it's fair to force people into making a choice between eating and taking medicine their doctor thinks they should have. In addition, my doctor has told me that I should have home help since I am not able to do everything myself. Obviously, that is out of the question, and Medicare will not pay for it. As if these problems were not enough, my doctor recently told me that I must start going on a kidney machine in the future, and I have

no way of getting to Grand Rapids for the treatments. Something must be done to help people with long-term illnesses such as mine.

DANNY L. PETERSON, C.P.C.
DIRECTOR

PROJECT: SODA

2415 14th Avenue South Escanaba, Michigan 49829
(906) - 786-9234

Date: August 27, 1987
To: Senator Reigle
From: Danny L. Peterson, Director Project S.O.D.A.
Subject: Senate Hearing on Health Care Issues

This brief statement is intended to discuss a little known, but often serious, problem of limited or total lack of private insurance coverage for various disorders affecting young people.

Project S.O.D.A. is a counseling program for families and youth with six offices in the Upper Peninsula. Each year we receive nearly 500 referrals for behavioral problems. Frequently, our counselors see clients who are exhibiting sets of behaviors indicating eating disorders or learning disabilities. In the majority of instances we lack the necessary resources in the U. P. to properly diagnose or treat such disorders as training for doctors and other professionals is inadequate. The financial and physical resources to provide long term care, when it is indicated, are practically nonexistent. Both in-patient and out-patient resources to treat the disorders are scarce due in part, we believe, to a lack of third party coverage.

Approximately 15% of all females in their teens and early twenties experience bulimia. Anorexia nervosa is being increasingly identified and is approaching epidemic proportions. One of every one hundred females is affected. Attention Deficit Disorder (A.D.D.) is a learning disability which seriously damages a young person's ability to concentrate, often leading to disasterous results in school and at home.

We cannot afford to ignore these disorders. We urge you to do all you can to encourage insurance coverage for these young people, as the vast majority of them can be helped - given the proper tools to do so. Through increased knowledge, early identification and treatment we can prevent the long term costs to society in both financial and human terms.

Thank you for your consideration of this matter.

STATEMENT OF WILL PURNELL, SOUTHGATE, MI

In 1963, Will Purnell was severely injured in a high school football game. He was in a coma for more than a month at Wayne General. He had both brain and eye surgery at Wayne. Because Will's father had died eight years before, Will received Medicare which paid for all of the treatments at Wayne General.

After checking out of Wayne General, Will was put in the mental ward at Eloise Hospital for approximately one year. During this time, he was given medication which, he believes, was a cause of severe migraine headaches and a loss of coordination.

Since leaving Eloise, Will has been living at home with his mother. He has been unable to work, and has lived off of his father's Social Security, which [illegible]948 per month. Will has had ongoing medical problems which are not covered by Medicare. Specifically, his big toe was ripped out of its socket in an accident three years ago. He has had to have repeated treatments to try to straighten out his toes. These treatments are not covered by medicare. Thus far, Will's doctor has been generous in donating whatever services are not covered by Medicare. In the fall, however, Will must undergo foot surgery, and this will not be covered, nor will it be donated. Will is concerned about paying Medical bills, since he has no real income and no way to buy insurance.

STATEMENT OF ARTHUR SUGARMAN, ADMINISTRATOR,

HERITAGE HOSPITAL, TAYLOR, MI

Heritage Hospital, located in Taylor, Michigan, is a 281 bed facility of Peoples Community Hospital Authority, a health services organization serving Out-Wayne County and Eastern Washtenaw County. Hospital services include home health care and a 70 bed in-patient Mental Health Unit. Catastrophic health care coverage is a major concern to community hospitals such as Heritage. Medicare eligible patients comprise about 50% of our general hospital census and about 90% of the home care patient count.

While the number of catastrophically ill patients at Heritage in a given month represents a small percentage, about 3% of our monthly census, 25 out of 835, resource consumption, financial and managerial impact is strongly disproportionate to this number. Impact is experienced most markedly in levels of cost of that care and effect upon patient, family and hospital quality of life.

LEVELS OF CARE:

Problems associated with appropriate levels of patient care are experienced in both the general hospital and behavioral medicine services. First there is a gap in the continuum of patient care in access barriers for intermediate skilled nursing care facilities to which to discharge or assign patients. A typical example is the chronically ill patient with no family support who could receive care at home, but 24-hour non-skilled and pharmaceutical care are not covered by insurance unless delivered in a hospital, which is defined and priced for acute care. Another example is the ventilator patient who has stayed 448 days, because no skilled nursing facility can be found to accommodate her special needs. Her bill totals $489,052, of which the hospital absorbed nearly, $300,000.

Such problems could be helped by extending coverage to services other than in-patient by implementing the revised recommendations for home health coverage and skilled nursing services; alternatives to more expensive in-patient care. Extension of coverage to include pharmaceuticals would also reduce financial effects of catastrophic illness. One ventilator patient had charges of $142,680 over 60 days of hospitalization.

FINANCIAL IMPACT:

Financial burdens caused within our system relate to unpaid debts and cash flow.

A recent two month review of selected catastrophically ill ventilator patients provided the following information typical of our caseload. Length-of-stay for reviewed cases ranged from 30 to 448 days. Total billing during that period for 19 selected cases was $764,745.00 ($666,355 Medicaid patients, $98,390 Medicare patients). Total payments from Medicaid/Medicare were 15% of total billing. Medicaid ranged from 7% to 48% reimbursement of charges, Medicare ranged from 3% to 27% reimbursement of charges. Our hospital absorbed about 85% of total charges, or $650,033.00 for the two month term.

In addition, MPRO and private payor review of extended lengths-of-stay and related services may occur six months to one year after discharge. Results of such review may take another six months to one year, depending on case complexity. Consequently up to two years after a given catastrophically ill patient has been discharged, the hospital may be denied reimbursement and must compensate for those revenues which have already been included within long-term planning. An example is a 48 year old stroke patient who purchased private insurance, prior to having a stroke. Upon review, the insurance company decided that the patient had a pre-existing condition and refused payment for services. This patient weighed 300 lbs. and required a special bed. Post-discharge placement of the patient required an $8,000 purchase of bed by the family and approximately $2,500 per month to maintain the patient in a skilled care facility.

Denial statements are frequently vague or non-existent. Of 42 denials received by this Hospital in the last year, 69% either contained no reason for denial or did not reference which of several services had been the reason for denial. Most common response is, "unreasonable and unnecessary".

This ambiguity does two things. It may perpetuate the same mistakes or it may force hospitals to narrow the services they provide to catastrophically ill persons, consequently reducing the units of service and ironically creating the perception that these services are either of minimal consequence or not needed. In addition, ambiguous, unclear admitting diagnosis guidelines do not allow flexibility in treating all ailments with which a patient may enter the hospital.

QUALITY OF LIFE ISSUES:

Quality of life for patient and family or support network is a serious concern at Heritage Hospital. We see patients spend life savings prior to being discharged just to cover hospitalization costs. Patients who have limited private pay insurance, those who are uninsured or underinsured, must exhaust all resources before being eligible to receive Medicare/Medicaid coverage.

Forced into an inappropriate level of care because of coverage constraints which do not focus on the most independent, as well as least expensive level of care, patients lose control over the quality of their lives, self-esteem and capability for self-management, self advocacy.

In conclusion, we strongly support recommendations made by Jack Owen and today's representative on behalf of the American Hospital Association. As a provider committed to a high quality of care, we require specific and clear definition of service entitlement provided by catastrophic health care benefits coverage, and greater flexibility under DRG limits to move patients into the most independent least expensive and most effective level of care for the individual's needs and resources.

STATEMENT OF LAURA SUTHERLAND, BIRMINGHAM, MI

Senator Riegle, I came to testify today in order to let you know what a catastrophic illness has meant to us. On August 27, 1984, I had a stroke that affected my neck and both sides of my body. The right side has mostly come back; the left side has not. We opted for home care instead of institutional care.

I thought we had saved up plenty of money for our retirement. How wrong I was! In the first five months I was home, we used up all of the over $40,000 we had in the bank.

The daily nurse cost $2,400 per month, but I should have 24 hour nursing. Medicare did not pay for the nurse, nor for other than prescription drugs, nor the medses I have to use for incontinence.

I turned 80 on July 24. I have also had to have a nurses aide for three days a week, 1½ hours per day. I have needed this care since I came home from another two months stay in the hospital in 1986. We pay over $104 per week for this "care". It seems to me that Medicare should pay for it.

Many people have catastrophic illnesses which wear them and their families down. Something besides costly insurance should be available for them

Alger - Marquette Community Action Board

112 West Washington Street ● Marquette, Michigan 49855 ● (906) 228-6522

August 25, 1987

Donald Riegle, Jr.
1207 Dirkson Senate Office Building
Washington, D.C. 20510

Dear Senator Riegle:

Thank you for the invitation to speak at the Senate Hearing you are conducting for Health Care to be held in Marquette on August 28, 1987. Due to another commitment, I will be unable to attend this hearing but do hope my written testimony will be entered into the hearing records.

My working relationship with Senior Citizens and disadvantaged low income citizens who have encountered long-term illnesses show that the people cannot afford to pay their hospital or prescription bills. In addition to the original illness, there very often is long-term out-patient treatment. The gasoline needed for transportation to the treatment center even becomes a burden let alone the cost of treatment.

The catastrophic illness causes devastating financial burdens, low morale, feelings of helplessness and frustration. Proud and independent people, who felt somewhat financially secure, have been "wiped out" with only one family member having a catastrophic illness.

Insurance premiums for the long-term illnesses are extremely expensive, which prohibits low or moderate income persons from purchasing this type of insurance. Medicaid is available only to the very, very low income person, and all too many people are just above the guidelines of any catagorical help.

Helping agencies such as St. Vincent De Paul, Salvation Army, Good Samaritians and Emergency Coalition have limited funds to help with prescriptions and generally no help for other medical bills.

I strongly feel that the United State Government should provide a type of insurance for catastrophic illnesses. The insurance needs to be within reasonable cost to lower and moderate income persons. If this is not made available, then I feel the guidelines for Medicaid need to be evaluated and should be adjusted to include persons with catastrophic or long-term illness.

AMCAB

In our Community Action Agency work we try every avenue of help available but all too often find ourselves on a "dead end" street. We see clients who do not eat properly in order to make a small payment on medical bills.

Thank you for chairing this meeting and thank you for your continued concerns about people.

Sincerely,

Gwen Dawson

Gwen Dawson
Outreadh Director

Alger - Marquette Community Action Board

112 West Washington Street ● Marquette, Michigan 49855 ● (906) 228-6522

August 13, 1987

The Honorable Donald Riegle, Jr.
United States Senate
Washington D.C. 20510

Dear Senator Riegle:

Thank you for your letter regarding the Senate hearing on health care issues to be held in Marquette on August 28th. Although I will be unable to attend, I would like to offer my concerns regarding programs for the low-income in reference to the elderly and chronically ill client.

It has come to my attention through numerous client contacts that a great many senior citizens and other clients suffering from long-term illnesses have exorbitant presciption drug expenditures that is not covered under medicare or their personal insurance. Therefore, the private citizen must incur the cost, which in many cases reaches well above $100.00 a month. It's unfortunate enough that he must spend a good portion of his very limited income on prescription drugs in order to stay alive or, at best, to live without severe discomfort or pain. But he is also denied services from low-income programs because his gross income is just above the guidelines. These programs do not make special allowances for medical expenses of the elderly or those suffering from catastrophic or long-term illnesses.

In the Community Action Agencies alone, the Weatherization and Targeted Fuel Assistance Programs follow the 125 federal poverty guidelines. These guidelines do not make special deductions for medical expenses from the gross income. How well are we serving our needy if the guidelines can't be flexible enough to consider medical costs that the client has no choice in paying? How can we penalize them for being sick?

Please let congress be aware of the discrepencies in the income guidelines for poverty programs in regard to citizens with ongoing medical costs. Their voice needs to be heard in Washington.

Thank you for your continued efforts in advocating for the economically distressed of our state as well as our nation.

Sincerely yours,

Annette Elmblad, Outreach Worker

COMMUNITY ACTION
PEOPLE HELPING PEOPLE

AMCAB

Alger - Marquette Community Action Board

112 West Washington Street ● Marquette, Michigan 49855 ● (906) 228-6522

August 11, 1987

Mr. Karl Numinen
323 Federal Building
Marquette, Michigan 49855

Dear Karl:

My letter is in response to your post card on the Public Hearing on Health Care being presented by U. S. Senator Donald Riegle on August 28, 1987. I am unable to be there physically, so let me share my input on the subject with you.

I have been a Community Action Outreach Worker for 10 years. During this time, I have processed a lot of Medicare and Medi-Gap insurance forms for senior citizens.

It has been my experience that under the subject of catastrophic care exceeding Medicare/Medi-Gap coverage expenses are becoming more and more an overwhelming burden to the recipients.

I just processed claims for a Medicare/Blue Cross recipient yesterday, and the recipient has to pay out of pocket expenses of over $1,000.00 for his wife's hospital stay, doctors, ambulance, etc.

Over the past years, I have processed claims for several clients dying of cancer, having Medicare/Blue Cross coverage, leaving bills of several thousand dollars for their spouses most of which have been women. Monthly, I process bills for senior citizens that have terrific expenses left to pay after their Medicare/Medi-Gap insurance pays. The spouses do not have money to pay these bills.

Also, prescription druges for our senior citizens are overwhelming. They go without necessities of life, including food, to pay for medicines.

In working with the younger disadvantaged groups (those just above the guidelines to qualify for Federal or State aid), I run into many individuals who have NO health insurance. They certainly can't afford to get sick!

I personally see a great need in the area of help for dental care. Rarely do any available programs address this growing problem.

COMMUNITY ACTION
PEOPLE HELPING PEOPLE

AMCAB

Many individuals, who have insurance coverage, are now left with overwhelming "Out-of-Pocket" expenses because their insurance company does not cover many necessary expenses.

Trying to battle the necessities of life these days is hard enough, but with the extra burden of health insurance leftover expenses that are not paid, it is becoming unbearable to many families.

Sincerely,

Betty F. Moore

BETTY MOORE
Outreach Worker

Alger-Marquette
Community Mental Health Center
1809 West Ridge Street, Marquette, Michigan 49855 906/225-1181
William G. Birch, Ed.D., Executive Director

August 28, 1987

SATELLITE LOCATIONS:

Outpatient Services

Alger County Office
County Office Building
Munising, MI 49862
906/387-3611

Ishpeming/Negaunee Office
Bell Memorial Hospital
Ishpeming, MI 49849
906/225-1181

Gwinn Office
Omni Building
248 East Wellington Drive
Gwinn, MI 49841
906/346-9307

Residential Homes

Wood Dale AIS/MR
FCSB
Munising, MI 49862
906/387-4357

Wood Ridge AIS/MR
169 Fairbanks
Marquette, MI 49855
906/225-7345

Hewett House
144 West Hewett
Marquette, MI 49855
906/225-7347

Activity Centers

Marquette Work Center
Rt. 2, Box 367, U.S. 41 East
Negaunee, MI 49866
906/225-7340

Munising Activity Center
Mill Street
Munising, MI 49862
906/387-4388

Grand Marais Activity Center
P. O. Box 344
Grand Marais, MI 49839
906/494-2372

Day Treatment

Bluff Street Center
122 West Bluff Street
Marquette, MI 49855
906/225-7355

The Honorable Donald Riegle
United States Senator
1207 Dirksen
Senate Office Building
Washington, D.C. 20510

Dear Senator Riegle: Don

I understand that you are playing a critical role in proposed legislation that would provide health insurance coverage for persons suffering from catastrophic and long-term illnesses, and persons who are uninsured or underinsured. This Center serves more than 2100 clients each year, with problems ranging from acute psychological crises to long-term developmental disabilities. While many of our clients have Medicaid, Medicare, or commercial insurances, an alarming number have no coverage at all (about 13%). A much higher percentage have insurance coverage that 1) does not cover psychiatric services; 2) severely limits the maximum annual or lifetime payment for mental health services, or 3) places uncreasonable restrictions on qualifications for clinical staff who may provide services. In fact, Medicare and Champus both place restrictions that in some cases do not provide for adequate care.

We believe that these restrictions are intended to limit insurers liability for psychiatric disabilities because they may be, by nature, severely disabling and long-term in nature. The irony in such limitations is that the persons who need the most care over the longest period of time are the ones who are denied benefits.

We strongly encourage you and your colleagues to include psychiatric services in the supplemental insurance plan, and that you write it in such a way as to allow the provision of services by carefully selected, trained, and supervised bachelor and master level clinicians. To limit coverage to physicians and psychologists, as many insurers do, needlessly raises costs and limits access to needed services.

Sincerely,

Bill

William G. Birch, Ed.D./MSW
Executive Director

cc: U.P. CMH Directors

020 North Front St.,
Marquette, MI 49855
August 24, 1987

U. S. Senator Donald W. Riegle
323 Federal Building
Marquette, MI 49855

Dear Senator Riegle:

Thank you for your letter of August 17, 1987 regarding the Senate hearing being held here in Marquette at Northern Michigan University on August 28, 1987.

Since I have a previous commitment that day and will be unable to attend I will share my concerns with you at this time.

First: I would like to know if this new catastrophic and long-term care policy would relieve the enormous financial burden of the unafflicted spouse or would the nursing homes just increase the cost of care, thereby rendering any additional help nil.

Secondly: Would the savings acquired by the couple be in jeopardy as is now the case either with Medicaid or a veterans facility?

Third: Would there by some provision for the spouse of the afflicted person so that they could enjoy a reasonable standard of living?

Fourth: Would such things as repairs to a home or additional unforseeable expenses be taken into consideration?

Thank you for your time and I sincerely hope these issues can and and will be addressed with both the Budget Committee and the Finance Committee and provide more help than is now available.

Respectfully,

Marie A. Bussiere

(Mrs.) Marie A. Bussiere

COUNTY BOARD
Robert Rivard
[redacted] Dennis Schaefer
Stafford Robinson

STATE OF MICHIGAN

DELTA COUNTY
DEPARTMENT OF SOCIAL SERVICES
2920 College Avenue
P.O. Box 376
Escanaba, Michigan 49829

JAMES J. BLANCHARD, Governor

DEPARTMENT OF SOCIAL SERVICES

AGNES M. MANSOUR, Ph.D., Director

August 26, 1987

Honorable Donald W. Riegle Jr.
United State Senate
323 Federal Building
Marquette, MI. 49855

Dear Senator Riegle:

Thank you for your invitation to participate at the hearing you are sponsoring in Marquette on the subject of Health Care.

The Delta County Social Services Board would like to use this means of sharing with you the problems of accessing health care for a large segment of our county residents.

It is very apparent today that adequate health care is only available to those who are fortunate enough to have either private resources or private insurance to cover the cost of good health care. The second group are those people whose limited income and resources place them on a poverty level which qualifies them for Public Health Care such as Medicaid in Michigan. If they are financially but not categorically eligible for Medicaid they may be eligible for State of Michigan General Assistance out-patient medical services or the Resident County Hospitalization inpatient services if in fact the county in which they live has budgeted sufficient funds for this purpose.

The large number of underemployed (low income) individuals and families who work in minimum paying jobs lack the resources and therefore the availability of health insurance for adequate continuous health care.

Many of these individuals, due to lack of access to preventative health care, find themselves in situations needing emergency treatment for acute health problems which leaves them with disabilities due to chronic health problems requiring long term treatment and care. The toll is tremendous when we consider both the need to lower their standard of living and overall adverse impact on quality of life.

It is obvious that a national health care program is needed to provide an ongoing, dependable health care system. It would provide the incentive for individuals to accept self-supporting or partial self-supporting employment without the worry of incurring debts for health care which they are unable to pay without denying themselves and their families basic daily needs of life.

The cost of public funds to pay for this expanded coverage of health care would be significantly offset by assessing, on the ability to pay, a minimal premium payment by the employee and also a premium payment for the employer. There would also be a significant number of people decreasing and/or terminating their Public Assistance benefits due to the incentive to accept lower paying jobs without a loss of health care coverage. This would mean that Senator Moynihan's proposed welfare reform legislation would need to be amended. His proposal to provide Medicaid for nine months after a person leaves the welfare rolls is a step in the right direction. However, in low paying closed ended jobs without a potential to acquire health care coverage, some assurance is needed that it would be available indefinitely.

We strongly support your continued initiative to pursue the passage of legislation which will provide access to health care for all our people at a reasonable and affordable cost to them.

We would like to take this opportunity to extend our appreciation to share our views on this extremely important issue.

Yours truly,

DELTA COUNTY SOCIAL SERVICES BOARD

Lawrence E. Curran
Executive Secretary

LEC/dmr

24920 Hickory
Dearborn, MI 48124

(313) 562-8316

July 27, 1987

Dear Senator Riegle

I am a registered nurse and the sister of a schizophrenia victim. My brother has had this brain disease for 40 years, the same length of time the National Institute of Mental Health has been in existence. He is 68 years old and the most productive years of his life have been wasted, imprisoned in psychiatric hospitals because of a no-fault brain disease. He is now in an acute care psychiatric hospital.

The financial cost to our family has been substantial, but for the U.S. taxpayer the cost has been mindboggling. It is impossible to estimate in dollars the cost in grief and sorrow. It has been, and still is, a nightmare of an experience for him and for our family. Like thousands of others, I have found support in the Alliances for the Mentally Ill.

This letter is an appeal to you for your support for more appropriate funding for research on severe mental disorders. The schizophrenia-research history of the National Institute of Mental Health over the past 40 years has not brought results. Please investigate why there has been so little productive research.

Please support adequate research funding. We will all be the beneficiaries of it.

Rose Dilloway

EWEN MEDICAL CLINIC
Box 66 • Hemlock and Elm Streets
Ewen, Michigan 49925
906/988-2210 · 906/988-2260

UPPER PENINSULA ASSOCIATION OF RURAL HEALTH SERVICES, INC.

August 20, 1987

Donald W. Riegle, Jr.
323 Federal Building
Marquette, Michigan 49855

Dear Senator Riegle:

As a Board Certified Family Physician who has practiced in the Ewen, Michigan area for one year now, I believe there are several major health care needs not adequately addressed for this area. I am a National Health Service Corp scholarship recipient and am serving my two-year commitment at Ewen. My clinic is part of the Upper Peninsula Association of Rural Health Services and is funded primarily from receipts as well as federal grants. Ewen is a medically isolated area,but even in areas with hospitals, there is great difficulty in recruiting physicians here.

I hospitalize my patients at Ironwood's Grand View Hospital and my colleagues are greatly over-burdened in terms of numbers of patients needing to be seen. The estimate for that hospital's service area, is that they could easily accomodate more family physicians in addition to the four who are already practicing full-time.

I personally feel that the National Health Service Corp has been extremely helpful in providing physicians for areas such as this. Currently, there are three Corp physicians in my service area and yet it is questionable whether there will be anyone to replace them once obligations are up, if they should decide to leave the area. Thus, although there was talk of a physician glut, in parimary care in rural areas, the exact opposite is the case. Given the fact that many medical students and thus residents end up with large debts to pay for their medical education, it seems still a reasonable approach to help these students with their debts in exchange for commitments to serve in a needed primary care setting. One plan that would get needed personnel into the pipe line more quickly to fill the gaps that the rapidly shrinking National Health Service is leaving, would be to agree to help current primary care residents such as family physicians with their debts in exchange for such service.

Among my patients, I find frequently that people are not seeking medical care when it would be timely for them to do so because of a lack of insurance. They usually are self-employed in an area such as this, making enough money so that they are not anywhere near Medicaid eligible, but would be financially ruined if they incurred any large bills.

Some of the small businesses locally do not provide health insurance to their employees and these working people are in a very vulnerable position. The local hospital realizes this problem and ends up regularly applying for Hill-Burton Funds to finance some of the large bills. Time and again, I have patients tell me that they cannot afford the tests I recommend and sometimes even the medications I prescribe because their relatively small income is already completely utilized. Seeing this fact of life, I have come to realize that moving toward a national health insurance for all citizens is a reasonable goal. This is not something I would have supported even four to five years ago. However, I do feel that good health care, like education, is a right of American citizens. The people I see currently most effected by the high prices of medical care today are not the unemployed people with no resources. In fact, it is the middle class who are working and either are not offered insurance through their jobs or cannot afford to pay the additional money required.

Unfortunately, I will be on vacation during you hearing on August 28th and will be out of the area. However, I hope that you collect useful information from other people besides myself and hope you find this feedback useful. I would be happy to talk further with you should you so desire.

Sincerely,

John E Hearst, MD

John Hearst, M.D.
Medical Director, Ewen Medical Clinic.
JH:rt

Helen Newberry Joy Hospital

Thomas W. Hicks
Administrator

502 West Harrie Street
Newberry, Michigan 49868
(906) 293-5181

August 17, 1987

Senator Donald Riegle, Jr.
United States Senate
Washington, D.C. 20510

Dear Senator Riegle:

In reference to your letter to Mr. Massoglia I wish to inform you that Mr. Massoglia recently passed away. I have taken his position as of August, 1986.

There is a great need for health insurance to cover long term care. In retrospective view of patients who have recently died here at the hospital, many were sick during the last two years prior to their death. During this time period they were sick enough to require care beyond what the family can usually provide, but not sick enough to be in the hospital. This gap is usually filled by nursing home care. While Medicare provides limited coverage for nursing home care, the criteria are very strict. This usually forces individuals to deplete their family savings until the point they are eligible for Medicaid. If there is a surviving spouse this creates a great hardship. There are no funds remaining after the spouse's death.

There needs to be some type of insurance for long term care. Due to problems with implementing a swing bed program in the state of Michigan, it would be advisable that this be a national program and not coordinated by each state. Michigan's lack of implementation of the swing bed program further compounds the problem in a community with limited nursing home beds. Therefore, the long term care insurance should be a national program in which the states could not have any influence.

I am sorry that I will be unable to attend your hearing on August 28, 1987. I hope my comments were helpful.

Sincerely yours,

Thomas W. Hicks
Administrator

TWH/dah

713 N. Sixth Street
Marquette, Michigan 49855
August 24, 1987

Senator Don Riegle
Great Lakes Room - University Center
Northern Michigan University
Marquette, Michigan 49855

Re: Catastrophic Health Care Ins.

Dear Senator Riegle:

As I will be unable to attend the public hearing on August 28th, I would like to bring my concerns to your attention.

My husband has been diagnosed as having Sub Cortical Dementia. While I am still able to care for him in our home I feel that other arrangements for his care will have to be made in the near future. How I will manage this financially is keeping me awake nights. Our savings are not great and keeping my husband in a medical institution will deplete them rapidly. What will be left for me to live on - maintaining our home, car, insurances, etc. as well as my own health needs. This is the question I would like to see addressed and some sort of solution offered.

Thank you for your interest and help in this sort of situation.

Sincerely,

Anne E. Holliday

Anne E. Holliday

HOUGHTON COUNTY MEDICAL CARE FACILITY
1100 QUINCY STREET • HANCOCK, MICHIGAN 49930 • TEL. (906) 482-5050/51

August 19, 1987

Honorable Donald W. Riegle Jr.
United States Senator
US Senate
Washington D.C. 20510

Acocks Medical Facility
AUG 25 1987
RECEIVED

Dear Senator Riegle:

We are writing to you in regard to the Senate hearing on Health Care Issues, specifically catastrophic and long-term illnesses.

We support the concept of catastrophic illness needing a cap, after which the person(s) would not be required to pay. The cap should be graduated based upon income and should not have an age requirement.

The second issue is long-term insurance which is, we are sure, a very complicated one. As an administrator of a 197 bed Skilled Nursing Care Facility, I have seen very few patients who have had long-term nursing care insurance policies which cover more than the medicare deductibles and co-insurance fill-ins.

Since the Medicare Program in the Long Term Skilled Nursing Care Facilities has become a farce, in that the restrictions imposed upon covering a patients care for payment by Medicare has become almost non-existant. This has of course been a landslide profit to the private insurance companies who sell long-term Medicare fill-in policies. When Medicare doesn't pay, most policies for fill-in coverage do not pay either.

There are a few good insurance policies available on the market which cover long-term care after Medicare or when it will pay but in talking with the local insurance agents the people in this country have been hood-winked into believing that Medicare will pay their bills. So limited is Medicare payment in Skilled Nursing Care Facilities that most patients are denied coverage upon admission, based upon medical determinations according to Medicare rules, that the older person does not find out they have no coverage until it is too late. Because they believe that Medicare will provide the services, they do not purchase private insurance.

We believe that a law authorizing or requiring private long-term insurance coverage will have little effect on the persons that it is intended for, unless these people understand that Medicare offers little or no long-term care coverage. Therefore, an education program is needed, probably even more than a law.

You have asked about current problems. We believe that there is a growing need to be able to provide ways and means to meet older peoples needs outside of institutions. Many programs currently address these needs such as Home Health Care, Meals on Wheels, Hospice and now there is a trend toward "Respite" care. This brings the need of "Day Care for the Elderly" to the forefront. This is particularily true of Alzheimers patients who in many

cases are being cared for by relatives at home. Day care can in many instances be provided in a Skilled Nursing Facility but currently this is impossible if it is Medicare or Medicaid certified. This is due to the method of "dumping" costs into what is termed a "non-reimbursable cost center" through the Medicare and Medicaid Cost Reporting systems of allocation of costs. This is further prohibited by the fact that funds are not available to pay the costs necessary to provide these services.

Skilled Nursing Care Facilities generally could allocate current staff and necessary space for such a program which could include medical evaluations, maintenance physical therapy and activities programs. Since these services are generally available to inpatients the "Day Care" patients could be incorporated right along with the inpatients for their scheduled day. This would serve to relieve the responsible person who cares for them at home and provide a "change of pace" for the patient. A meal and even in some cases where space permits a bed to lie down could also be provided.

The cost could be realistic if the current cost finding procedure of segragating these persons costs from Medicare/Medicaid could be worked out so that the effected areas in the facility would not be considered as non-reimbursable areas into which Medicare and Medicaid costs could be dumped by these program intermediaries.

To summarize we believe that:

A. Catastrophic illness is a present danger looming over all of us. It needs a Federal Policy with a graduated cap according to income.

B. Long-Term Insurance is needed but will not succeed until the public is told that Medicare Skilled Nursing Care is minimal in coverage.

C. "Day Care" for the elderly is needed to help keep persons out of institutions and costs down.

We thank you for your kind consideration and the opportunity to have input.

Yours truly,

CBrusso

Clifton Brusso
Administrator

CB/rj

Aug. 29, 1987

Honorable Senator Don Kiegle:

I have first hand experience with catastrophic and long-term illness of my husband Elmer J. Jones, 75 yrs of age, afflicted with Alzheimers. He has been a resident of Superior Shores Nursing Center & Rose Haven Nursing Center Hopewell, Va. since May 13, 1986.

Our insurance MCK & Medicare do not cover custodial care & Medicare covers other services) to a specified amount. At present I am private pay which costs $68 per day - $24,820 a year) plus medicines. My husband's income $331.00 Soc Sec & $332.00 CSA & I receive $171 Soc Sec

I am 75 years of age with advanced arthritis and eye problems and am managing a small rental unit & some Rangers which at present pay low interest I could have to spend everything to the property has often all these years of working for my husband and paying income tax except for the last year.

It would be a blessing to get a reasonable amount of relief for my husband's expenses. I would go for an increase and the V.C.R rate, also I feel it would be only right if the spouse was relieved tax on her share of the "marking marie" estate.

I am glad you are trying to do something for us.

Thank you,

Marie L. Jarvis
116 E Diamond #1
Shepherd, Mo. 49849

906-486-4692.

P.S. The doctor finally placed my husband in the hospital and nursing home after a difficult time at home. I had difficulty getting help as he was very aggressive and incontinent. He was moved 3/13/86 by ambulance from Bell Memorial Hospital and is staying in contract to Superior Shores Nursing Center and Nursing Home told if I didn't approve the move that V.C.R would not pay for hospitalization. Marie Jarvis

Psychology

Phone 228-4420

SCOTT R. MATTHEWS, Ph.D., P.C.
MARQUETTE MEDICAL-DENTAL CENTER
1414 WEST FAIR AVENUE — SUITE 122
MARQUETTE, MICHIGAN 49855

August 28, 1987

The Honorable Senator Donald W. Riegle, Jr.
United States Senate
Washington, D.C. 20510

Dear Senator Riegle:

Thank you for inviting me to testify at the Senate hearing on health care issues, focusing specifically on catastrophic and long-term illnesses, the under-insured and the uninsured, held in Marquette on the 28th of August, 1987. I am sorry that I was unable to stay long enough to be able to testify and I am hoping that the following information will be useful to you and your colleagues in deliberating over the legislation you are proposing.

Insurance for catastrophic and long-term illness for the under-insured and the uninsured is both reasonable and appropriate legislation if implemented wisely. Since long-term debilitating illnesses affect not only a person's body and pocketbook, but also the psychological well-being of both the person and the person's family, it is important to include mental health care as an equal and concomitant part of any treatment plan. It would be wise in legislation such as you are proposing to follow the leadership of Senators Matsunaga and Inouye, who have introduced legislation (S123) to include psychologists among eligible Medicare providers. The Medicare exclusion of psychologists is an unwanted anachronistic anomaly in the mental health care system. People who have chronic or lingering illnesses have significant unmet needs for quality mental health care. Letting them utilize psychologists permits them to express their individual preferences for providers just as other insurance beneficiaries are permitted to do so in almost all health care reimbursement systems. It also provides for greater access to expanded expertise, while at the same time exerting competitive pressures to minimize cost. The cost of psychologists' inclusion would not only be minimal but most likely would be offset with the inevitable patient determined shifting from providers with higher fees to providers who charge lower fees, and from the reduction in non-mental health medical utilization. Additionally, psychologists are often preferred for their mental health care needs over other health care professionals. Also, psychologists are more accessible, more evenly distributed geographically through all regions of the country, especially here in the Upper Peninsula, where there are very few psychiatrists to service a very large area. As well as the above, psychologists are also often more highly specialized and trained in geriatric mental health care and other therapies, such as biofeedback, etc.

There are two American traditions or freedoms that need to be addressed here. The proposed wholesale sell-out of our citizens' rights to choose and the potential monopoly by only one health care provider group needs to be avoided in your legislation. The route chosen by Sen. Edward Kennedy and Rep. Henry Waxman to include a provision that amends the Employment Retirement Security Act to pre-empt all state mandated freedom of choice and minimum health care benefit laws is woefully short-sighted. I would propose the type of legislation that would provide catastrophic and long-term illness

insurance be carefully written to include, along with the freedom of choice, another long-held American tradition, and that is competition in the health care marketplace.

I would urge you to carefully weigh Americans' rights to freedom of choice for their mental health care providers and a healthy competition in the marketplace rather than to deny patients their rights as is proposed by that feature of the Kennedy-Waxman legislation which would exclude psychologists.

I was most touched and impressed by your sense of caring and the sense of friendship I felt from you as you addressed our large audience in Marquette, and I would be very pleased to speak with you further on any of the issues as regarding psychologists. I know that as a member of the Budget Committee, you must be ever aware of increasing costs, and yet there is a considerable body of data to suggest that psychologists in the long-run have a tendency to reduce medical costs rather than to increase them, and I hope you will consider this when formulating your legislation and in voting on the other issues facing you in the Senate. If I can be of any help to you, please do not hesitate in contacting me.

Sincerely yours,

Scott R. Matthews, Ph.D., P.C.
Licensed Psychologist

SRM/blb

Marquette County Department of Social Services
234 West Baraga Avenue
Marquette, Michigan 49855
(906) 228-9691

DRAFT

Honorable Donald W. Riegle, Jr.
United States Senate
Attention: Karl P. Numinen
323 Federal Building
Marquette, Michigan 49855

Dear Senator Riegle:

Many families turn to the Department of Social Services to deal with catastrophic and long-term illnesses. We are one of the primary agencies to implement federal and state initiatives which provide appropriate health services for all who need them regardless of their ability to pay. Unfortunately, we often fall short of this goal.

Today, I am speaking from my experience as the Director of the Marquette County Department of Social Services. I have also been authorized to present the views and the position of the Michigan County Social Services Association. Through these organizations, I have become aware of the many problems resulting from medical indigency. I hope to describe some of these problems, to note some of the good things we are doing, and to suggest a few ways which may provide greater access to appropriate health care.

Last year, a friend called to say that his son had been hospitalized. He was twenty-two years old, had been working part-time while looking for a full-time job. He was not covered by medical insurance, and his family was unable to pay the hospital bill. His son made application for Medicaid and for county hospitalization, but we found that he did not qualify for any assistance from our office. I personally reviewed the case and indeed the young man was not eligible. He received the care, but now owes the hospital several thousand dollars. Interest on the bill accumulates nearly as fast as he can afford to pay.

This case illustrates the plight of a large group of people between the ages of twenty-one and sixty-five. Increased numbers of Michigan citizens are not covered by medical or hospitalization insurance. The governor has estimated that more than 900,000 people in Michigan lack public or private health care benefits. More than three-quarters of these people are the working poor or their dependents.

People working in low-paying jobs often do not have adequate health care benefits. A recent survey by the Michigan Department of Social Services indicated that approximately fifty percent of those clients leaving welfare for employment were not covered by an employer-sponsored health plan. Of those who were covered, a majority remained off welfare. Of those not covered, up to eighty percent returned to welfare after a few months. In a local survey of clients in Marquette, lack of medical coverage was considered a major problems faced by clients who were no longer eligible for welfare benefits.

Most of these clients do not face catastrophic health problems. These people lack access to more basic services such as doctor visits, prescriptions, preventive care, and outpatient services. When lack of these services results in catastrophic conditions, the system responds and the person becomes eligible for the most costly forms of treatment.

Many other Michigan citizens have insufficient coverage for catastrophic conditions or for long-term care. In these instances, savings and resources are quickly exhausted. Once people become medically indigent, government programs may pay the bills, but the likelihood of returning to self-sufficiency is drastically reduced. Over ninety percent of our patients at the Marquette County Medical Care Facility are on Medicaid. Most of these people worked all their lives, but now have exhausted all of their savings. If their condition improved so that they no longer required care in a nursing home, they may have no place to go.

Despite these problems, the federal response to health care needs continues to decline. Congressman Howard Wolpe reports that more than $30 billion has been cut from the Medicare and Medicaid budgets over the last five years. The President's February budget proposal calls for an additional $6 billion in cuts in Medicare and Medicaid in fiscal year 1988 and $22 billion over the next three years.

The Robert Wood Johnson Foundation reports that "the proportion of the poor and near poor covered by Medicaid--the largest public program for the poor--has dropped significantly from 63 percent in 1975 to an estimated 46 percent in 1985. Although a few states appear to have been able to maintain the scope of their Medicaid coverage, the program's ability to reach those with incomes below the poverty line has been losing ground since the mid-1970's."

Despite these problems, several initiatives have expanded health care access. The Michigan Department of Social Services has developed a cost-effective Medicaid system. Increased use of HMO's has emphasized the benefits of preventive health care services. Each year, home health and home help services expand to reduce the need for more costly inpatient services.

In Marquette County and in Genesee County, the Robert Wood Johnson Foundation has sponsored innovative programs to increase health care access. We are testing the feasibility of the employer, the employee, and the state each paying one-third of the expense for health care coverage. We hope such incentives will increase the number of jobs covered by health care benefits.

There is still much to be done. The platform for the Michigan County Social Services Association identifies several goals for health services. These goals are listed as follows:

3. HEALTH SERVICES

MCSSA believes that health services, including preventive services, should be available to all people, and that a wide range of medical and health care services should be included in the public assistance program for those persons lacking the financial resources to purchase such services.

3.1 MCSSA encourages early and regular screening, diagnosis, and treatment of health problems.

3.2 Institutionalization of the mentally and physically disabled should be minimized in view of the potential benefits of family based care in the community.

3.3 Preventive dental care and appropriate treatment should be included among the services provided to clients.

3.4 All methods of family planning services available to the general public should be accessible to those persons on public assistance desiring the service.

3.5 Medical services should be delivered in the most efficient and cost-effective manner possible while guaranteeing basic health care for those most in need. MCSSA promotes cost containment plans such as Health Maintenance Organizations and supports the establishment of similar organizations.

Although we continue to seek improved local and state support for health care, we know that the problems cannot be solved without increased support and direction on the federal level. New health care initiatives are needed. Comprehensive programs focusing on prevention and early treatment must be integrated with programs for long-term care and catastrophic coverage.

We are apprehensive about the development of new initiatives for catastrophic coverage or for long-term care while at the same time reducing funding for Medicaid and Medicare. We support the new initiatives if current services are maintained and if proper emphasis is given to prevention and early diagnosis and treatment options. We also feel that efforts should continue to

improve the efficiency of health care delivery and to reduce overusage and provider fraud.

Thank you for the opportunity to comment on the need for expanded health care access. I appreciate your commitment to improved health care, and I stand ready to assist you with this goal in any way possible.

Sincerely,

David A. Berns, Director
Marquette County
Department of Social Services

DAB/ls

cc: Charles Higgins, President, MCSSA
Marquette County Board of Social Services
William Jewell, Zone Manager, M D S S
file

Republic Michigan
August 19,1987

Karl Numinen
323 Federal Building
Marquette Michigan 49855

Dear Sir:

I am writing you to ask Senator Reigle if he can do something about the price of medicine for us elders. Mine is about $200.00 a month plus payemant on a doctor nill of $45.00 and also for a hearing aid which is $25.00 a month. The month my BC&BS comes due I have a hard time to buy all my medicine. I have split some of the pills to make it do its purpose even if it is half a dose. I'm paying taxes and insurance o on my home and am on Social Security. I am 82 years old. I understand Senator Riegle is working to help the elders with catrotaphic medical bills. I pray he will succeed with his plans.

Thank you,

Mrs Lillian Peterson
Rt. 1 Box 253 Apt 4
Republic Michigan 49879

Mrs Lillian Peterson

July 11, 1987

The Honorable Senator Donald Riegle
109 W. Michigan
Lansing, MI 48933
Attention: Ken

Dear Sir:

As you requested, I am sending you this information, which should be pertinent in your research about catastrophic illness.

In 1964, I was graduated summa cum laude from the University of Michigan. Soon after, I worked as a secretary in a one-girl office. After a few years, during which I was married, I was engaged as Executive Secretary to the President and Vice-President of a manufacturing concern. All the while, I remained Stage Manager and Lighting Director in a travelling opera company.

In the summer of 1972, I was diagnosed as having multiple sclerosis. We had adopted a baby boy. Five years later, my husband left me and we were divorced. I continued to raise the boy alone, as my condition worsened. I could no longer work. Now, the boy is living with my ex-husband and his new family.

My sight is badly impaired, and my hands are afflicted with tremors. I have not been able to walk for about four years. I must have around-the-clock help.

The judge awarded me the house, but also the mortgage payments. I cannot afford to pay them, nor the cost of the aides, their food, etc. My parents have accepted that responsibility. My father has been retired from his steady job, and my mother is self-employed. I receive Disability Social Security payments, and a small alimony. These have combined to put my "income" over the maximum necessary to receive Medicaid. So I must pay for my medication. I cannot afford to have the therapy my doctor orders, to prevent further deterioration or make some improvement.

I shall be glad to testify at the hearing on July 27th. Let me know what else I must do.

Yours truly,

Maxine Schwartz
(typed by her mother, M.Gordon)

August 28, 1987

The Honorable Donald W. Riegle, Jr.
United States Senate
Washington, D.C.

Dear Mr. Riegle,

The Senior American Coalition would like to thank you for your concern for the elderly citizens of Michigan's Upper Peninsula. Your hearings on catastrophic and long-term illnesses are indeed timely and of great importance. We thank you for your invitation to us to provide testimony on the needs of your constituency.

In addition to catastrophic health insurance, our community needs "Catastrophic Moving Insurance". The elderly of our area who are dependent on government reimbursements for long term care are being transported far away from their homes, families and support systems due to the shortage of immediately available nursing home beds. We seek your help in making sure that this problem is addressed by the arrangements between the federal and state governments.

Enclosed is a packet of materials which documents the problem of the exile of our weakest and most frail members of society to nursing homes far away from their loved ones and home community. We stand ready to be of whatever help we can be to find a remedy to this situation. We look forward to further communication from your office.

Thank you.

Sincerely,

A. Kracke

A. Kracke
Executive Director
Senior American Coalition

The Honorable Donald W. Riegle, Jr.

United States Stenate

SENIOR AMERICAN COALITION
P.O. Box 4
Hancock, MI 49930

KEEP
OUR
PEOPLE
HOME

Documents

on

Long Term Care Needs

Cover Letter

Review of the study done by the Michigan Department of Public Health in 1986 to determine the Long Term Care needs in Michigan's Upper Peninsula

Grass Roots Letters of Support

Documentation of Specific Cases

Transfer Statistics from one hospital

Newspaper Articles on the issue of the need for more nursing home beds

August 28, 1987

BETHANY LUTHERAN CHURCH
OF KEWEENAW

MOHAWK, MICHIGAN 49950

Pastor Nathan Sager
Church: 906-337-2662
Parsonage: 906-337-2177

August 24, 1987

To the Respected Members of
The State Health Coordinating Council,

When the Department of Health completed its Long Term Health Care Study, the facts were carefully studied by the Senior American Coalition. Regrettably, the study did not draw any recommendations.

The Senior American Coalition formulated and approved the following recommendations:

1. THANKS to the Health Department for their objectivity and openness to hear about the critical need of our elderly for Nursing Home beds.

2. REVERSE the Nursing Home bed quotas which call for a REDUCTION in the number of desperately needed Nursing Home beds by 1990.

3. RECOGNIZE that elderly go into Nursing Homes because they can no longer care for themselves or be cared for in their own homes and that Home Health Care is NOT an alternative to Nursing Homes.

4. TRAIN those who come into contact with the elderly on a daily basis to be alert to signs of the need for further health care.

5. WORK WITH churches to improve the services to our aging population.

We hope and pray that you will take these recommendations into consideration as you discuss the formula which determines Nursing Home bed quotas.

Let us work together to see to it that justice is done for the seniors of our state.

Sincerely,

Nathan Sager
The Reverend Nathan Sager

A SAMPLE OF FINDINGS OF THE LONG TERM HEALTH CARE STUDY

1. The average # of people per square mile:
   UP: 19 State of Michigan: 153

2. People 60 years and old
   UP: 20% of the population or 62,600
   State of Michigan: 10.7%
   Counties with very high proportions of 60 years and older: Gogebic, Iron, Keweenaw (Houghton & Marquette offset by university populations)

3. Problems of rural elderly
   a. Higher # of elderly deaths fromchronic diseases
   b. Higher # of persons in poor health
   c. Fewer physicians than state health care plan in Keweenaw, Houghton, and Ontonogon counties
   d. Fewer nurses than state health care plan
   e. Longer distances to travel to the doctor, hospital, or nursing home
(Over 5 times as many long term beds per 100 sq. miles in lower Michigan
   f. Extremely harsh climate and heavy snow fall

Nursing Home Beds
1. At the time of the report, 99 patients in 20 hospitals surveyed were awaiting placement in Nursing Homes
2. Nursing Home beds available a. 34 Nursing facilities with 2,579 beds
   b. UP: One bed per 20 people
      State of Michigan: one bed per 18 persons
   c. Occupancy rates: 99%
   d. Nursing Homes had an average waiting list of 16
   e. Average wait to get into a home was 66 days

Home for the Aged Beds
1. Beds available
   a. Number of homes: 10 Number of beds: 450
   b. Occupancy rate: 93%
   c. Average waiting period: 1-2 months
2. Limitations to Home for Aged
   a. Custodial not medical care
   b. Not reimbersable by Medicaid (73% of Nursing Home patients receive Medicaid reimbersements)
   c. Lack of permanence--need for more care will necessitate move to a Nursing Home

Long Term Bed Formula for the UP
1. By 1990 Recommended DECREASE in Nursing home beds for the UP: 14% or 369 beds
   (3 UP counties (Chippewa, Mackinac and Marquette will get 42 additional
   Recommended decrease for the State of Michigan: 11% or 5,452
2. Recommended increase in Home for the Aged beds: 509
3. By county

	Nursing Home	Hm for Aged
Houghton	-19	+124
Ontonogon	-29	+32
Keweenaw	--	--

4. Recommendations of the report--
   Still in Executive Committee of the Health Department as of August 26, 1987. Study began in Nov. 1985 and was completed except for recommendations in Jan., 1987.

HOUGHTON COUNTY COMMISSION ON AGING
P.O. Box 249
South Range, MI 49963

August 24, 1987

Ms Toni Kracke, Director
Senior American Coalition
P.O. Box 4
Hancock, MI 49930

Dear Ms Kracke,

On behalf of the Houghton County Commission on Aging I commend you and the Senior American Coalition for the strong efforts you are putting forth on behalf of our older citizens of the area particularily as it comes to supporting the great need for more nursing home beds here.

It has been an issue on our agenda more than once because many of our people are concerned that should the time come that they would be in need of a nursing home bed situation they might find one here rather than be sent hundreds of miles away from family, friends and Pastor or Priest. This has been the case recently only too many times. I have known a few situations personally where I believe the person would have lived longer and certainly not have been as lonely in their last days.

You are well aware that we have beds at every one of our local hospitals that quite likely could be used in these situations if allowed to. Also I think you are aware that one of the local nursing homes, Dube's Our Lady of Mercy in Hubbell, MI has applied for permission to add to their facility and are ready to do so when permission is granted.

You have our support in helping to make the "powers that be" more aware of our special situation here in the U.P. and more particularily in the Copper Country.

Sincerely,

Roy R. J. Tahtinen, Chairman
Houghton County Commission on Aging

Tel. 906-337-2229

COUNTY OF KEWEENAW
COURTHOUSE
EAGLE RIVER, MICHIGAN 49924

August 17, 1987

State Health Coordinating Council:

The State of Michigan Health Department conducted a "Long Term Care Study" which proved there is a shortage of nursing home beds in our area and that our nursing homes have 99% occupancy, but yet recommends a 14% decrease for nursing home beds by 1990.

We are concerned as many of our residents have to leave the area now for nursing home care and are torn away from their families and as approximately 50% of our county population are senior citizens we see no lessening of the need for nursing home care.

We ask that you would not consider the Health Department formula decreasing nursing home beds in our area but consider our unique conditions.

Sincerely yours,

Donna Lassila /mw

Keweenaw County Board of Commissioners
Donna Lassila, Chairman

BERNICE M. HUOTARI
ONTONAGON COUNTY CLERK AND REGISTER OF DEEDS
COURTHOUSE
725 GREENLAND ROAD, ONTONAGON, MICHIGAN 49953
(906) 884-4255 or 884-4257

August 19, 1987

State Health Coordinating Council
Lansing,
Michigan

Dear Council Members:

I am writing in behalf of the Ontonagon County Board of Commissioners.

At their regular meeting, Tuesday, August 18, 1987, action was taken to support the efforts of the Senior American Coalition in their endeavor to secure additional long term care beds for the Upper Peninsula of Michigan.

The board is concerned that citizens of the area are removed from their home communities because of the shortage of immediately available nursing home beds.

Please correct the unfortunate system that the nursing home bed formulas have caused immediately. The unique conditions and needs of this area must be taken into account and dictate necessary action.

Thank you for your earliest consideration.

Very truly yours,

Bernice M. Huotari

Bernice M. Huotari, Clerk
Ontonagon County Board of Commissioners

County of Houghton

COUNTY COURTHOUSE, HOUGHTON, MICHIGAN 49931

TO: State Health Coordinating Council

FROM: Houghton County Board of Commissioners:
Gerald A. Perreault, Chairman
W. Clarence Dwyer, Vice-Chairman
Jackie A. Niemi, Commissioner
Robert J. Lowney, Commissioner
Gordon E. Jukuri, Commissioner

SUBJ: Bed Shortages for the Elderly DATE: August 17, 1987

The Houghton County Board of Commissioners is acutely aware of many health problems experienced by senior residents of Houghton and other neighboring counties. Our specific immediate concern is the shortage of nursing home beds for the long term care of the elderly. We are alarmed over formulas which actually prescribe decreases for nursing home beds in the U.P. by 1990. That prospect is unimaginable.

Members of the Senior American Coalition have invited us to support them in their efforts to obtain more beds for the area. Please be advised that the county board whole-heartedly endorses their attempts to persuade you to review factually and rationally the unfortunate system that nursing home bed formulas have created.

Thankyou,

THE HOUGHTON COUNTY BOARD OF COMMISSIONERS

State of Michigan)
County of Houghton)

I, Raymond J. Hosking, County Clerk and Clerk of the Houghton County Board of Commissioners, do hereby certify that the above was adopted by said Board, at a Regular Meeting, held on August 11,1987.

In Testimony Whereof, I have hereunto set my hand and affixed the Seal of the Circuit Court, at Houghton, Michigan, this 17th day of August, 1987.

Raymond J. Hosking, County Clerk

Baraga County Clerk
Courthouse
L'Anse, Michigan 49946

AUGUST 12, 1987

Elizabeth M. Makela
County Clerk
Telephone 906-524-6183

Darlene M. Smith
Deputy

L. James LaForest
Deputy

STATE HEALTH COORDINATING COUNCIL
LANSING, MICHIGAN

GENTLEMEN:

THE BARAGA COUNTY BOARD OF COMMISSIONERS IS CONCERNED ABOUT THE NURSING HOME BED SHORTAGE IN BARAGA COUNTY. WE FIND THAT WE HAVE TO SEND SOME OF OUR ELDERLY TO NURSING HOMES OUTSIDE OF THE AREA. THE ELDERLY ARE PUT ON LONG WAITING LISTS IN ORDER TO BE ADMITTED TO HOMES IN THE AREA.

FAMILIES WOULD LIKE TO HAVE THEIR ELDERLY STAY IN BARAGA COUNTY WHERE THEY CAN BE CLOSE TO THEM WHEN THEY CAN NO LONGER CARE FOR THEM AT HOME.

I KNOW FAMILIES FEEL A GREAT LOSS WHEN THEY ARE ADVISED BY THEIR DOCTORS THAT THEIR ELDERLY PARENTS HAVE TO BE PLACED IN A NURSING HOME. IT IS A GREAT EMOTIONAL EXPERIENCE, ONE THAT I HAVE GONE THRU, BUT IT IS MORE SO WHEN THAT PARENT HAS TO LEAVE THE COMMUNITY FOR NURSING HOME SERVICES.

SINCERELY,

Elizabeth M Makela

ELIZABETH M. MAKELA
BARAGA COUNTY CLERK

FROM THE PAAVOLA SENIER CITIZENS CLUB

WHERE-AS

OUR SENIER RESIDENTS ARE BEING TRANSPORTED FAR FROM THEIR HOMES, AND THEIR LOVED ONES,BECAUSE LACK OF NURSING HOME BEDS.

AND WHERE-AS

THESE SENIOR RESIDENTS ARE ALREADY TOO WEAK TO STAND THIS KIND OF TREATMENT AND WHERE THE LOVED ONES DO NOT HAVE THE TIME AND TRANSPORTATION TO GO AND SEE THEM TOO OFTEN,WITH THE NURSING HOME SO FAR APART IN THE UPPER PENINSULA.

AND WHERE-as

THERE IS A LOT OF OCCUPANCY IN OUR OWN RESIDENTIAL NURSING HOMES FOR OUR SENIER RESIDENTS,ONLY THAT WE LACK THE NURSING HOME BEDS.

THEREFORE:-

THE SENIER CITIZENS OF PAAVOLA MICH GO ON RECORD TO SUPPORT THE REQUEST OF COMMISSIONERS OF BARAGA,KEWEENAW,HOUGHTON AND ONTONOGON COUNTIES,TO THE STATE HEALTH COORDINATING COUNCIL TO INVESTICATE,WHAT CAN BE DONE ABOUT THIS NURSING HOME BED SHORTAGE SITUATION IN THE UPPER PENINSULA.

ARVO-A. PYORALA Secr

Arvo A. Pyorala
Secretary

Dear Senior American Coalition Friends,

From July, 1986, to June, 1987, my mother, Saima Secor, age 88, was an unhappy resident of Shady Lane Nursing Home in Manitowoc, Wisconsin which is 275 miles from her home in Calumet.

Because of a fall at home she required nursing home care while she recuperated. The nearest available bed was in Iron Mountain which is half way to my home in Manitowoc, so it seemed logical for her to enter a nursing home there.

My father, age 92, remained alone in Calumet until Thanksgiving when he closed the family home for the first time in winter and he moved in with my husband and me in Manitowoc. In May, 1987, he returned to Calumet.

Because it was shut off all winter the refrigerator motor wasn't working and could not be repaired. The cost of a new one was $873.59.

The plumbing leaked in many places (pipes, toilet) after being turned back on, requiring replacement and repairs. The cost was $894.12.

The emotional trauma to our whole family (I have three brothers on the west coast) cannot be measured in dollars, can it? We believe our mother's recovery would have been months shorter if she could have been here, especially if her friends could have visited her and encouraged her. Many months of depression, rebellion (for a time she even refused food and had to be spoon fed) and needless confusion could have been avoided if a nursing home had been available in the Copper Country.

Our prayer nad sincere hope is that Michigan's heart turns toward her precious "seniors" to reach out when they need a helping hand!

Dr. & Mrs. Carl Kobelt (Janet Secor), 1017 Lincoln Blvd.
Manitowoc, WI 54220

SHADY LANE HOME, INC.

[illegible] SOUTH FORTY-FOURTH STREET

MANITOWOC, WIS. 54220

Aug. 19, 1987

To whom it may concern:

Mrs. Saima Secor was a resident at Shady Lane Home from July 3, 1986 thru May 22, 1987.

Her total cost for room and board including supplies for this period of time was: $11 337.95

1986	July	$ 870.00
	Aug.	912.30
	Sept.	951.85
	Oct.	950.20
	Nov.	946.20
	Dec.	929.20
1987	Jan.	1122.60
	Feb.	1128.00
	Mar.	1124.40
	Apr.	1122.00
	May	1124.60
	June 1-4 bedhold	146.60
		$11337.95

Lucille R. Eachman
Financial Secretary

AMBULANCE FEE $495.00

PLUMBING FEES $894.12

REFRIGERATOR $873.59

PHARMACY (NORTH END DRUG) - $539.81

PHYSICAL THERAPIST $145.00

MILEAGE FROM CALUMET TO MANITOWOC - 3 TRIPS - ~~825~~ 1650 MILES

Lydia Maki is the spouse of Antone Maki a victim of Alzheimer's, diabetes, four strokes in six years with paralysis on the left side, and impaired vision. Lydia lives in Kenton, MI and when Antone needed to be put into a nursing home in 1985 there were no beds available in the Upper Peninsula so she was forced to bring him to Phelps, WI.

To visit Antone, Lydia must travel 110 miles round trip. This limits her visits. It also limits the visits he receives from other family and friends as it is not always easy to travel great distances when you are aging as most of his friends are.

The high cost of keeping Antone in a nursing home takes most of their monthly income and causes Lydia to live on the savings they have. To date Lydia has spent over $60,000.00 in expenses for Antones care above and beyond what the insurance pays which is very limited. Antone has gone into comas and needed to be transferred into the hospital but in order for his bed in the nursing home to remain available Lydia must pay the $56.00 a day to reserve his bed. If she did not do this his bed would be released to someone on the waiting list for the nursing home.

The insurance coverage Lydia has is very slow in paying any of the expenses for drugs and other related supplies. She said it takes many months for Blue Cross to pay and often things get mixed up and must be sent back more than one time. This causes more delays. Lydia wonders what can be done to get things done more quickly and correctly. She does not want to go on Medicaide.

Lydia would like to have Antone closer to home but there are no beds available.

STATEMENT

NORTHWOODS HOSPITAL
PHELPS, WISCONSIN 54554
NURSING HOME PHARMACY
TAX ID No. 39-0782130

THEODORE KRUSE, ADMINISTRATOR
PHONE 715/545-2313

Re: Mr. Anton Maki

Mrs. Lydia Maki
Box 118
Kenton, MI 49943

84-357 0252

DATE	REFERENCE NUMBER	DETAIL	CHARGE	PAID	BALANCE FORWARD / BALANCE
7-31-86	62	Slow K 8mEq	6 20	109861	
	31	Lanoxin 0.25mg	7 35	109862	
	62	D.S.S. with C	2 73	109863	
	186	Aspirin gr. X	3 98	109864	
	90	Dipyridamole 50mg	9 68	109865	
	90	Isordil 10mg	7 47	109866	
	31	Xanax 0.25mg	11 75	109867	
	31	Furosemide 40mg	6 45	109868	55 61

SAFEGUARD BUSINESS SYSTEMS

PAY LAST AMOUNT IN BALANCE COLUMN

9-16 Blue cross check
10-7-86

NORTHWOODS HOSPITAL
PHELPS, WISCONSIN 54554
NURSING HOME PHARMACY
TAX ID No. 39-0782130

THEODORE KRUSE, ADMINIS
PHONE 715/545-2313

RE: ANTON MAKI

MRS. LYDIA MAKI
BOX 118
KENTON, MI 49943

DATE	REFERENCE NUMBER	DETAIL	CHARGE	PAID
1986 12-31	62	Haldol 2 mg	16 81	
	62	Furosemide 80mg	9 04	
	93	Capoten 25mg	31 04	
	62	K-Lyte CL 25mEq	13 00	
	30	Lanoxin 0.25mg	8 16	
	186	Aspirin gr. X	4 14	
	93	Dipyridamole 50mg	9 15	
	93	Isordil 10mg	7 54	
	1	Monovalent Flu	5 00	

PAY LAST AMOUNT IN BALANCE COLUMN

683

STATEMENT IN ACCOUNT WITH

NORTHWOODS HOSPITAL ASSOCIATION

PHELPS, WISCONSIN 54554 3/3 19 87

TO Mrs Lydia Maki
Box 118
Kenton, Mich 49943
re: Anton Maki

BAL. ACC'T. RENDERED	
ROOM & CARE PER DAY	
March 1987 31@ 52.00	1612.00
ANESTHETIC	
OPERATING ROOM	
DELIVERY ROOM	
CARE OF INFANT	
X-RAY	
ULTRA SOUND	
AMBULANCE	
1st Neb attend 2.00	
SURG. DRESSING & SUPPLIES	113.35
DRUGS	
EMERGENCY ROOM	
ELECTROCARDIOGRAM	
99 hrs @ 30¢ per hr	29.70
LAB FEE & PATH EXAM	
CAST	
PHONE	
TOTAL	
CREDITS	
BAL. AMT. DUE	1755.05

NORTHWOODS HOSPITAL

PHELPS, WISCONSIN 54554

NURSING HOME PHARMACY

TAX ID No. 39-0782130

THEODORE KRUSE, ADMINISTRATOR
PHONE 715/545-2313

RE: ANTON MAKI

MRS. LYDIA MAKI
BOX 118
KENTON, MI 49943

DATE	REFERENCE NUMBER	DETAIL	CHARGE	PAID	BALANCE FORWARD / BALANCE
2-28-87	14	Lanoxin 0.25mg	4 89		
	100cc	EES 400mg	6 68		
	8	Furosemide 40mg	4 09		
	1	Digoxin 0.125mg	3 76		
	8	Rocephrine 1gm	194 65		
	10cc	Regular Insulin	9 95		
	1	Keto-diastix	12 14		236 1
			Bd. March 3.87		50.-
					186.1

SAFEGUARD BUSINESS SYSTEMS

PAY LAST AMOUNT IN BALANCE COLUMN

STATEMENT IN ACCOUNT WITH

NORTHWOODS HOSPITAL ASSOCIATION

PHELPS, WISCONSIN 54554 8/5 1987

TO Mrs Lydia Maki
Box 118
Paxton, Mich 49943
re: Paxton Maki

BAL. ACC'T. RENDERED		
ROOM & CARE PER DAY		
Aug 1987 31 @ 56.00		1736.00
ANESTHETIC		
OPERATING ROOM		
DELIVERY ROOM		
CARE OF INFANT		
X-RAY		
ULTRA SOUND		
AMBULANCE		
116 mile Ambulance @ .75 per		87.00
SURG. DRESSING & SUPPLIES		
DRUGS		
EMERGENCY ROOM		
ELECTROCARDIOGRAM		
OXYGEN		
LAB FEE & PATH EXAM		
CAST		
PHONE		
TOTAL		
CREDITS		
BAL. AMT. DUE		1823.00

STATEMENT IN ACCOUNT WITH

NORTHWOODS HOSPITAL ASSOCIATION

PHELPS, WISCONSIN 54554 7-2 1987

TO Mrs Lydia Maki
Box 118
Paxton, Mich 49943
re: Paxton Maki

BAL. ACC'T. RENDERED		
ROOM & CARE PER DAY		
July 1987 31 @ 56.00 per		1736.00
ANESTHETIC		
OPERATING ROOM		
DELIVERY ROOM		
CARE OF INFANT		
X-RAY		
ULTRA SOUND		
AMBULANCE		
126 miles Ambulance @ .75 per		94.50
SURG. DRESSING & SUPPLIES		
DRUGS		
EMERGENCY ROOM		
ELECTROCARDIOGRAM		
OXYGEN		
LAB FEE & PATH EXAM		
CAST		
PHONE		
TOTAL		
CREDITS		
BAL. AMT. DUE		1830.50

7/1/87

STATEMENT IN ACCOUNT WITH

NORTHWOODS HOSPITAL ASSOCIATION

PHELPS, WISCONSIN 54554 4-6 19 87

TO Mrs Lydia Mahi
Box 118
Kenton, Mich 49973
Re: Aston Mahi

	BAL. ACC'T. RENDERED	
	ROOM & CARE PER DAY	
April 1987 30 @ 52.00		1560.00
	ANESTHETIC	
	OPERATING ROOM	
	DELIVERY ROOM	
	CARE OF INFANT	
	X-RAY	
	ULTRA SOUND	
	AMBULANCE	
131 medium attends @ .75 ea	SURG. DRESSING & SUPPLIES	98.25
	DRUGS	
	EMERGENCY ROOM	
	ELECTROCARDIOGRAM	
	OXYGEN	
	LAB FEE & PATH EXAM	
	CAST	
	PHONE	
	TOTAL	
	CREDITS	
	BAL. AMT. DUE	1658.25

STATEMENT IN ACCOUNT WITH

NORTHWOODS HOSPITAL ASSOCIATION

PHELPS, WISCONSIN 54554 6-4 19 87

TO Mrs Lydia Mahi
Box 118
Kenton, Mich 49973
Re: Aston Mahi

	BAL. ACC'T. RENDERED	
	ROOM & CARE PER DAY	
June 1987 30 @ 52.00		1560.00
	ANESTHETIC	
	OPERATING ROOM	
	DELIVERY ROOM	
	CARE OF INFANT	
	X-RAY	
	ULTRA SOUND	
	AMBULANCE	
153 medium attends @ .75 ea	SURG. DRESSING & SUPPLIES	114.75
	DRUGS	
	EMERGENCY ROOM	
	ELECTROCARDIOGRAM	
	OXYGEN	
	LAB FEE & PATH EXAM	
	CAST	
	PHONE	
	TOTAL	
	CREDITS	
	BAL. AMT. DUE	1674.75

Pd June 5, 1987

Senator Riegle's Budget Hearing- Marquette, MI-

IN response to your request to hear about health care costs and underinsurance.I submit the following:

In 1986 my husband developed health problems. He was 62 years old and unable to work, so he retired on Social Security. We have paid for our own health insurance since 1982 when he was terminated from a full time job and converted the company's health insurance to a group conversion policy. We pay $1117.20 per year for health insurance.

During 1986 we paid $363.81 for his prescription drugs. Medical bills came to $940.80, which was mostly for testing to try to find what was wrong. The test results came back inconclusive. The doctor wanted him to go for a biopsy which would cost $1500.00, which would tell whether he had muscular dystrophy or not. The medical costs were already at $940.80, none of which our health insurance covered. We looked at it objectively- none of the money spent was for curing him and this test wouldn't either, so he didn't go, because our savings were going down rapidly. With health insurance that costs that much and will only pay $65.00 a day for a bed and doesn't seem to cover hardly anything else, it appears that paying for health insurance all these years was almost foolish on our part. We should have saved that money and put it on medical expenses when needed, instead.

Now during 1987 he is still two years away from Medicare and the doctor is saying that he is facing a need for surgery for another health problem. With health insurance that pays so poorly, our savings would probably be wiped out since we are not eligilbe for Medicaid. He may also have serious health problems which are still undiagnosed for which we could not afford to do anything, because we wouldn't have the means to pay for them.

If another insurance company would even consider insuring us it would mean that we would have to carry the old policy for at least a year, before we would be insured under the new one for existing illnesses. That would be costly.

He worked all his life, travelled a long distance to work, skimped and saved to have something for retirement, was terminated well before retirement due to economic conditions, then worked seasonal jobs, and now finds that he cannot afford health problems, due to poor quality health insurance and also the high cost of health care. He probably couldn't afford it under Medicare either.
We need more affordable health care and insurance in our country. Even Medicare seems to be for the financially better off.

Helen Leinonen
Rt 1 Box 150
Pelkie, MI 49958

First Hand Report On Moving An Elderly Gentlemen

I wonder how many of you have had the haunting experience of driving a man in his 80's with a physical handicap (exaggerated hump on his back and severe curvature of the spine) to a nursing home some 133 miles from home after he has been in the hospital "his allotted time". That was over a 3½ hour drive when you have to stop at a restroom and those feet do not move well since he is in a weakened condition.

All of those miles he continually asked the following questions which continue to haunt me and make me mad:

"Why are they doing this to me? I paid my taxes and served in the army with the rest of my family.

Why are they taking my hometown friends away from me?

I haven't broken any laws.

There's room on 4th floor at Calumet Public Hospital. Why can't I stay there until one of the local homes open up?

I worked to support my family during my lifetime. The State didn't support them all their life like they did so many.

Are they trying to kill the people of the Copper Country?

Why is the State doing this to us?

Oh, I'm so tired. How much longer is it? My back and neck hurt.

I can't understand our government treating us like this. We're like prisoners being shipped off to Siberia where people can't be with their families.

You won't forget to come down to see me, will you? You've helped me and visited me so long."

That Wednesday afternoon I drove him as a friend rather than to have the State pay an ambulance for 266 miles round trip. Since I am employed full-time and I had a conflict the following weekend, I didn't get over to see him and reassure him that we had not forgotten him. By the following weekend he had been transferred a little closer to home and died of what the nurse called "a plain broken heart - he just gave up." Nobody had been able to visit him the rest home. His friends are too old to make a round trip like that and are on limited incomes so can't afford food and lodging away from home. To him it was the feeling "yes, they deserted me" and that's tragic! Even more tragic is the fact we have the facilities to take care of them at home and are not allowed. If they were to total the ambulance fees vs. the 4th floor fees in Calumet Public Hospital for a couple days, the results would often balance in favor of the hospital. Something needs to be done.

Deloris I. Langseth
P.O. 523
Calumet, MI 49913

8/19/87

PROPSED CANDIDATES FOR AUGUST 28 BUDGET HEARING
Senior American Coalition

Contacts: Toni Kracke, Executive Director, SAC
Suomi College
482-5300 or 337-3713

Ross Aden, Gloria Dei Lutheran Church, Hancock
482-2381 or 482-2184

1. VI MOEHRKE
1211 Front St.
Lake Linden
296-0674

Her mother, ELEANOR ALANEN, is an 82 year old woman who was a former Redridge resident. When her husband died and in failing health, she moved to Heritage Manor where she spend 3 years and was loved by all who got to know her for her generosity and spirit. She has a heart contition, high blood pressure, and other medical complications which made her subject to falling and passing out. She was hospitalized on May 2, 1987, and was told that she could no longer live in her apartment even with assistance from the family but had to go to a Nursing Home. Her funds were very limited and this meant that she would be dependent on Medicare. As no nursing home beds were immediately available in the Copper Country, she was taken to the home in Florence, Wisconsin where she spend 5 weeks until a bed became available at the Houghton County Medical Care Facility.

Eleanor's story appeared in the Houghton GAZETTE soon after she was transferred to Florence.

This was a tramatic and seemingly needless trip for Eleanor who was very lonely in Florence. While there, she did not receive any physical therapy and was confined to a wheelchair. But they started therapy for her as soon as she came to the Medical Care Facility. Her daughter Vi made 6 trips to Florence in 5 weeks, although she was in poor health herself and surgery was imminent. When Vi did go in for surgery, the doctor stated that she was so run down and her blood pressure was so low that he was considering postponing the surgery and that it would be some months before she would get all her strength back.

2. LAWERENCE BROUILETTE
Rt. 1 Box 193
Calumet, Mi. 49913
296-0103

Lawerence's mother was Mrs. ANTOINETTE BROUILETTE was a resident at Still Waters Nursing home but became too disable to be kept there as it is Home for the Aged. The family was given the choice of having her transported either to the Soo or to Florence, Wisconsin, because she was on Medicare, needed a nursing home, and none was available in

(over)

the Copper Country. She spent a month there and while there a doctor examined her and stated that because of her heart problems she should never have been subjected to stress like that (of being transferred so far away). She was transferred back to the Houghton County Medical Care Facility but she died soon thereafter.

Mrs. Brouilette had no savings and was dependent on Medicare and her Social Security and therefore had to go wherever she was told to go. Her case points out how life-threating as well as emotionally upsetting a forced move to a distant nursing home can be.

BACK-UPS

3. ANITA ROWE
1662 Laurium St.
Calumet, Mi. 49913
337-0200

ARTHUR ROUX was Anita's uncle who lived in the Laurium Senior Housing Apartments. He was found outside on winter day in 1985 after having fallen. Anita's father (Arthur's brother) got a call from the hospital saying that he was being transferred to Florence, Wisconsin. The family had not been consulted or notified, and they had 20 minutes to get his clothing together. Arthur's dad did not even get see him before he left for Florence.

Arthur died in Florence. When I talked to her in mid-July, Anit's aunt, FLORENCE SANDRETTO was in intensive care at the Calumet hosptial suffering from breathing problems, diabetes, and a heart condition. It looked like she too was going to be taken to Florence.

The problem about testifying is that Anita and the rest of the family who experienced this are going to be attending a wedding out of the area for the weekend of August 28

4. ARMAND J. BARIL
Houghton County Medical Care Facility
Hancock, Mi. 49930

Armand is now back in the Copper Country, but in 1986 he had to have a total knee joint replacement at the V.A. hospital in Iron Mountain. Since no nursing home beds were available after his surgery, he was transfered to the American Nursing Home in Kingsford Michigan. Finally he was transferred back to Hancock. I have not asked about the possibility of his testifying

5. AMELIA YLITALO
(Now deceased, family in the area)

When she became too confused to stay in her home any longer, there were not beds available in area nursing homes, so she was transferred to Ontonogon. Soon thereafter, she got out of her wheelchair and broke her hip. She was finally transferred back to the Medical Care where her family could see her and where she did much better.

Transfers from Calumet Public Hospital, 205 Osceola St, Laurium, MI
to long term care homes or units

DATE	#	DESTINATION (Out of County)		#	MILES	ROUND TRIP
6-84	9	Maple Manor	Ontonagon, MI	1	72	144
7-84	5	Winkler	L'Anse, MI	1	45	90
8-84	6	Americana	Kingsford, MI	1	133	266
		Villa	Florence, WI	2	230	460
		Maple Manor	Ontonagon, MI	3	216	432
9-84	5	Winkler	L'Anse, MI	2	90	180
		Villa	Florence, WI	2	230	460
		Sault Ste Marie	MI	1	285	570
10-84	4	Americana	Kingsford, MI	1	133	266
11-84	9	Winkler	L'Anse, MI	2	90	180
		Barage Longterm	L'Anse, MI	4	180	360
12-84	8	Winkler	L'Anse, MI	1	45	90
6 month Totals		Villa	Florence, WI	1	115	230
	46			22	1,864	3,728
1-85	5	---				
2-85	9	Mather Inn	Ishpheming, MI	1	115	230
3-85	6	---				
4-85	8	Winkler	L'Anse, MI	2	90	180
		Maple Manor	Ontonagon, MI	1	72	144
5-85	9	Villa	Florence, WI	1	115	230
		Maple Manor	Ontonagon, MI	1	115	230
6-85	9	Maple Manor	Ontonagon, MI	1	115	230
7-85	9	---				
8-85	2	---				
9-85	4	---				
10-85	7	Goegebic	Ironwood, MI	1	122	244
		Winkler	L'Anse, MI	1	45	90
			Phelps, WI	1	115	230
11-85	5	---				
12-85	3	---				
1985 Totals	81			10	904	1,808

Deloris A. Langseth
Senior American Coalition
Advocacy Committee

Dawn Papineau
administrator 8/30/87

Transfers from Calumet Public Hospital, 205 Osceola St., Laurium, MI

DATE	#	DESTINATION (Out of County)		#	MILES	ROUND TRIP
1-86	6	---				
2-86	4	---				
3-86	8	---				
4-86	7	Gogebic	Ironwood, MI	1	122	244
		Winkler	L'Anse, MI	1	45	90
5-86	7	---				
6-86	7	Maple Manor	Ontonagon, MI	2	144	288
		Superior Shores	Munising, MI	1	161	322
7-86	5	Maple Manor	Ontonagon, MI	1	72	144
		Villa	Florence, WI	2	230	460
8-86	4	---				
9-86	6	Gogebic	Ironwood, MI	2	244	488
			Iron River	1	115	230
10-86	7	Gogebic	Ironwood, MI	1	122	244
11-86	10	---				
12-86	11	Villa	Florence, WI	1	115	230
1986 Totals	82			13	1,370	2,740
1-87	6	Villa	Florence, WI	1	115	230
2-87	7	Gogebic	Ironwood, MI	1	122	244
3-87	6	Gogebic	Ironwood, MI	1	122	244
			Iron River, MI	1	115	230
4-87	10	---				
5-87	2	---				
6-87	4	Ontonagon Long Term	Ontonagon, MI	1	72	144
		Maple Manor	Ontonagon, MI	1	72	144
		Villa	Florence, WI	1	115	230
7-87	7	Ontonagon Long Term	Ontonagon, MI	3	216	432
To Date 1987	42			10	949	1,889

Deloris A. Langseth
Senior American Coalition
Advocacy Committee

Dear Paperwork
Administrative Aide

The Daily Mining Gazette, Monday, May 4, 1987

Needs of U.P. elderly greater than rest of state

By SUZANN SHERMAN
Gazette writer

HANCOCK — Nearly half of Keweenaw County's residents over the age of 65 have no central heating in their homes and one out of 10 has no indoor plumbing, according to a Michigan Department of Public Health study.

According to the report, based on 1980 census figures, the Keweenaw elderly ranked number one in the heating category and number three in the plumbing category statewide.

Alger, Luce and Mackinac counties were the other U.P.'s counties ranked in the central heating category. Three other U.P. counties — Ontonagon, Houghton and Baraga counties placed in the top 10 ranking in the report's plumbing category.

All of the U.P.'s counties were mentioned at least once on the report's top 10 ranking of five major categories in the study.

The report indicated that 13.4 percent of Ontonagon County's elderly are without indoor plumbing, followed by Alger (9.9 percent), Keweenaw, Houghton (8.4 percent), and Baraga (7.3 percent).

Keweenaw, Ontonagon, Baraga and Baraga counties were mentioned most often in the study.

The Michigan Department of Public Health report discussed the findings as part of a comprehensive study called Long Term Care in the U.P.

The report also indicated that 28.1 percent of Keweenaw County's elderly between the age of 65 and 74 live alone and that 31.7 percent of persons aged 75 or older live alone.

Compared to state averages, U.P. counties consistently have higher percentage ratings in several studies. A 1986 needs assessment prepared for the Office of Services to the Aging pointed out that "the needs of this area are different and in some cases of greater magnitude than the needs of older people in other parts of the state."

The study based its findings on telephone interviews of 1,224 senior citizens over the age of 60 between June and September 1985. The interviews averaged 47 minutes. Milan J. Dluhy, Ph.D., an associate professor of social work at the University of Michigan, and several assistants prepared the report.

The U.P.'s elderly are older (70.8 percent here vs. 68 percent statewide), have more Catholics (34.6 percent vs. 23.7 percent), and most live in small towns (47.8 percent) or rural areas (27.4 percent). The statewide figures are 30.8 percent and 18 percent respectively.

On the positive side, the U.P.'s elderly are more likely to have their mortgage paid off (91 percent) than statewide (75.5 percent). In addition, the U.P.'s elderly are less likely to think about moving and more likely to be living in a home over 50 years old, the report said.

The report blamed "a general lack of knowledge of services available" for the "consistent low service utilization" among the U.P.'s elderly.

The five most frequently used services were health screening (41.4 percent), library (38.4 percent), congregate meals (25.4 percent), education (23.2 percent), and hearing impaired services (16.2 percent).

Statewide averages for service utilization were higher than the U.P. average in 14 categories. Some examples of the broad differences are emergency needs assistance: statewide 12.5 percent, U.P. 9.2 percent; housing assistance: statewide 7.9 percent, U.P. 2.8 percent; emergency home monitoring: statewide 7.1 percent, U.P. 1.4 percent.

Cont. on Page 3

Elderly report

Cont. from Page 1

When asked whether the senior citizen would use the service were it available at a reasonable cost, the U.P.'s elderly indicated they would use 21 out of 28 service categories, if they were available, the assessment said.

In only one area — crime prevention — did the statewide interest in service exceed the U.P.

"The question of availability and the level of resources in these service areas should be carefully examined in order to bring current service levels more in line with service demand," the report said.

Hypothetical use of rides, such as [illegible] car; age, disability or income. To a lesser extent, living with someone other than a spouse, being widowed or female, and low education were also good predictors, according to the report.

"Low income is by far the best, and most consistent, predictor of need," the report said. "Low income is associated with: a dependency on others for transportation; a dissatisfaction with housing and neighborhood; a poorly insulated home by [illegible]; a need for help in the daily activities of living; a poor physical and mental health status; a perceived need for a wide range of services; and a self report of many serious problems."

From the senior citizen's perspective, poor health is considered their most serious problem. When interviewed, 23.1 percent said they had been sick in bed in the last six months; 23.4 percent said they had been hospitalized in the last year; and 7.3 percent said they had received help at home because of their health problems. However, 86.5 percent of those hospitalized in the last year have been discharged with no services, the report said.

While there are other needs that may emerge from examining the needs assessment report, "careful documentation of need is essential to the efficient use of public and private resources for the older population in Michigan," the report concluded.

re Daily Mining Gazette

Serving The Western Upper Peninsula For 128 Years.
Thursday, May 14, 1987

35 Cents

Lottery

The winning number in Wednesday's state Daily drawing is 129. The Daily 4: 8018. Lotto: 20, 26, 28, 29, 33, 34.

U.P. long-term care bed shortage acute

By SUZANN SHERMAN
Gazette writer

HOUGHTON — Eleanor Alanen sat in her wheelchair dressed in a gray two-piece suit and corsage in honor of her 82nd birthday. The next morning, she traded the suit for a hospital gown.

Five days later Alanen was well enough to leave Portage View Hospital, but not well enough to return to what she calls her "little dollhouse" — Heritage Manor in Houghton.

Rev. Ross Aden of Gloria Dei Church, where Alanen is a member, says no nursing home bed was available for Alanen "in the whole U.P." so she spent the night with her daughter and the next day moved 114 miles away to Florence, Wis.

"It's too far away," laments Mrs. Alanen's daughter, Vi Moehrke of Lake Linden. "Even if it were in L'Anse, we could visit her every day, but her friends who are old cannot come that far. It's hard enough for us."

"What happened to Mrs. Alanen is not unusual," Aden added. "In fact, here in the U.P. there's a likelihood of it becoming the norm instead of the exception."

Rev. Aden is in a position to know. He was a representative on the 28-member coordinating committee of the study called Long Term Care in Michigan's Upper Peninsula.

The study, conducted by the Michigan Department of Public Health in 1986, documents the "particularly urgent" long-term care needs of the U.P.'s elderly population, said Aden.

Two contributing factors cited by the report are the rural nature of the U.P., which "exasperates" long-term health care, and the "stressful circumstances" the elderly here experience.

Despite urgent needs, the report shows that there are over five times as many long-term care beds per 100 square miles in lower Michigan than in the U.P.

However, the health department's current "Long Term Bed Methodology" calls for a 14.5 percent reduction in U.P. nursing home beds by 1990 compared to a 19.7 percent reduction in the entire state. This would amount to a reduction of 19 beds in Houghton and Keweenaw counties.

The report "is pretty comprehensive and covers a lot of ground, but it fails to make any recommendations," Aden says. "Until that happens and something concrete is done, we have really not accomplished much for patients like Mrs. Alanen."

(Continued on Page 3)

Bed shortage

(Continued from Page 1)

Aden is also a member of the Senior American Coalition (SAC), a Lutheran Church in America outreach ministry to the aging in a four-county area of the U.P., which participated in the health department's long-term care study.

"SAC and other groups made recommendations to the health department. We also critiqued the study. There are flaws in it but it's a beginning — more than our elderly population has had before," Aden said.

According to Aden, Dr. Marcia Carlyn, chief of the health department's division of research and development, and project director of the study, is convinced that "pockets of need" do exist in the U.P.

Statistics confirm the assessments of Aden and Carlyn.

"The rurality of the U.P. is demonstrated in the number of hospital and long-term care beds per 100 square miles. While the state as a whole has 725 hospital beds per 100 square miles, the U.P. has only 96," the study said.

In addition, records indicate that the state as a whole has 855 long-term care beds per 100 square miles, while the U.P. has 157.

Locally, Houghton County has 325 nursing home beds with a 100 percent occupancy rate while 109 homes for the aged have an occupancy rate of 89 percent. "It is this predicament which precipitated Mrs. Alanen's move to Florence, Wis.," Aden said.

"We don't need more homes for the aged beds as the state is proposing. The figures point that out," Aden stressed.

Homes for the aged, which have an average waiting period of one to two months, provide custodial care and are not reimbursable Medicaid.

However, 73 percent of nursing home patients receive Medicaid payments and a study said 96 patients in U.P. hospitals surveyed were awaiting placement in nursing homes. In 1986, the average home had a waiting list of 16 people who would wait at least 66 days for placement.

While recommending additional home for the aged beds, the state's long term bed formula indicates a 1 percent decrease in nursing home beds in the U.P. by 19 The recommended decrease for the state is 11 percent.

The shortage of U.P. nursing home beds is compounded by Wisconsin's liberal certificate of need process which has made it possible for Michigan patients to be placed in Wisconsin nursing homes near the Michigan border. Patients like Mrs. Alanen transferred from a Michigan hospital to a Wisconsin nursing home automatically become a Wisconsin resident.

"This accounts for the state's proposed reduction in nursing home beds. The statistics make it look like we don't need any," said Aden.

For Mrs. Alanen, however, the situation is not likely to change in her lifetime. She's in poor health and far from home which won't help her recovery any," Aden said.

"She is one more statistic for the Long Term Care report," Aden concluded.

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SUPERIOR SURGICAL, P.C.

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M. F. Santini, M.D.
Certified American Board of Surgery
GENERAL, THORACIC, & GYNECOLOGICAL SURGERY, ENDOSCOPY

R. A. Armstrong, M.D.
Certified American Board of Surgery
GENERAL, THORACIC, VASCULAR SURGERY AND ENDOSCOPY

August 26, 1987

The Honorable Donald W.Riegle, Jr.
323 Federal Building
Marquette, MI 49855

Re: SENATE HEARING ON HEALTH CARE ISSUES

Dear Senator Riegle:

Thank you for your correspondence of August 17, 1987 concerning your upcoming senate hearing on health care issues. Unfortunately, because of my schedule, I will be unable to attend or testify at your upcoming meeting in Marquette. I would like to take this opportunity to respond to your request for written statements.

You asked what the most pressing concern in the Upper Peninsula of Michigan is concerning funding for our governmental health care system. I think without a doubt at this time the most disturbing aspect of our current system is the tremendous differential in payments received by rural and metropolitan hospitals.

As a member of the Board of Trustees at Grand View Hospital, I follow our monthly reimbursement for Medicare very closely. As a medical staff member I see on a day-to-day basis what the DRG reimbursements are for specific diagnoses. I can say, unequivically, that our hospital is not in a profit position with regards to Medicare. Most disturbingly, we are not even in a break-even position. This is not because we are not providing what we consider to be excellent medical care for the Western Upper Peninsula. Our length of stay for most illnesses is much shorter than in many metropolitan hospitals. Our costs are somewhat less, but actually not that much less than most metropolitan hospitals.

The simple fact is that the current DRG system, as it is applied to Grand View Hospital, is not providing adequate reimbursement to continue running the system in this manner. We must rely on excess revenue from private insurance and other sources to make up the deficit created by caring for Medicare patients. This results in a draining of funds which could be used for capital improvement and other necessary medical programs and equipment needs at the hospital. This has a crippling effect when we must compete with surrounding metropolitan areas.

I believe that it should be a top priority of our senators and representatives to modify the current Medicare reimbursement system so as not to cripple the rural portion of that system.

After being in practice for three-years in Ironwood, Michigan, I am convinced that the patients are better cared for if they are able to remain in their own community and be cared for locally by their own physicians. The government's current trend is to encourage patient's to travel to metropolitan areas and to encourage hospitals to transfer all patients that may drain funds from the local hospital to metropolitan areas. In the long run this is simply not beneficial to the patient, the family or the local community hospital.

I would call for a complete revamping of the DRG system as it now exists. I think that it is a crime that we see some metropolitan hospitals actually having windfall profits under the current DRG system, when us in the rural areas, are struggling to get by.

With regards to the catastrophic health insurance, almost any illness suffered by a family or an individual patient of the Western Upper Peninsula could be considered catastrophic. Most of the people in our area have limited means. Many of them cannot afford or simply do not have health insurance. Any illness which results in hospitalization and the financial drain that that produces results in a catastrophic burden on that family. My personal feeling concerning this topic, is that the government should offer some type of catastrophic health insurance at a low cost to the underprivileged. Exactly how underprivileged would be defined or what this insurance would cover would have to be worked out by a committee of legislators and physicians.

I am sorry that I do not have much more input on the catastrophic insurance proposal, however, my major concern is the survival of our community hospital. I see the catastrophic health insurance as a relatively minor problem when compared with the huge differential reimbursement between rural and metropolitan areas.

I appreciate your requesting my input on this matter and if I can be of any further assistance to you or any of your staff in the future in gathering information or providing input, I will be more than happy to do so. Please feel free to contact me at my office or Grand View Hospital at any time.

Most sincerely yours,

Richard A. Armstrong, M.D.

RAA:mc

U. P. CENTRAL INSURANCE AGENCY
John T. Gray, General Agent

P. O. Box 522
Marquette, MI 49855
906-228-7330

NEW PHONE # (906) 225-0300

August 28, 1987

U.S. Senator Don Riegle
105 Dirksen Bldg.
Washington, D.C. 20510

Dear Senator Riegle;

Thank you for allowing me to present the enclosed material that outlines my views and suggestions regarding catastrophic health insurance. I have been working in the insurance field, primarily with Senior Citizens, for over 5 years. During this time I have processed many claim forms and initiated appeals on several occasions. Because of this, I feel qualified to comment on the shortcomings of the Medicare System, including the Supplemental Plans that are being offered.

I have used the House of Representatives version of a catastrophic health care plan as a basis for my proposal. If I can be of further assistance on this matter, please don't hesitate to call on me.

Sincerely;

John T. Gray
General Agent

Public Hearing on Health Care
Northern Michigan University
Marquette, MI 49855

Attn: Senator Don Riegle

CATASTROPHIC HEALTH CARE COST

House of Representatives Bill - Problems

1. Self funded by the Medicare Recipients
   a. Additional Medicare premium and additional income tax on people with incomes above 1.5 times the poverty level
   b. No way to accurately estimate the cost of this proposed plan with some estimates up to 10 times higher than the figures used by the authors of the bill.
2. Prescription Drug Benefit - $ 500.00 deductible and 80% of cost of medication
   a. AIDS victims are Medicare eligable after a two year disability. By 1991 it is estimated that there will be 270,000 AIDS cases. On 4-27-87 their were 35,068 reported cases (Up to additional 25% unreported) . Estimated that cases will double every 5 years.
   b. Estimated cost of medication to combat AIDS to be $ 1000 per mo. for each victim.
3. Out Patient and Physician Charges (Part B)
   a. Limit out of pocket expenses to $ 1000.00 per calendar year.
   b. No regard to expenses above Medicare approved or eligable.
   c. True beneficiary of this benefit will be the Limited Medicare Supplement Policies, like Blue Cross and Blue Shield.
4. Hospital Expense (Part A) One deductible to cover all long term hospital bills.
   a. Only 3% of all Medicare patients remain hospitalized beyond 150 days
   b. Cost of Hospital Deductible is not a catastrophic expense.
5. Skilled Nursing Home - Coverage to 150 days and eliminate 3 day hospital stay
   a. Skilled Nursing Care is not a catastrophic expense.
   b. Long Term Confinement at reduced levels of care is the problem
   c. Eliminating the 3 day hospital stay requirement is not going to help anyone who does not enter a Skilled Home for Skilled Care.

5. Skilled Nursing Home (Continued)
   d. In most cases, a stay in a long term facility, that does not follow a hospital stay, will not require Skilled Care and will not qualify for this benefit.

Proposed Solutions

1. Prescription Benefit - $ 250 deductible - 80% of Medication Cost up to $ 2000/yr.
   a. Benefit will apply to more people
   b. Maximum cost can be computed and will be controlled
2. Out Patient - Physician Care (Part B)
   a. Require Medicare Supplements and Blue Cross/Blue Shield to cover expenses up to the Usual and Customary Charges.
   b. Allow individuals to pay the Medicare Supplement Premiums with no tax dollars.
3. Long Term Care - All levels of care in licensed facilities
   a. Require Long Term Policies to provide comprehensive care
   b. Allow individuals to shift tax exempt dollars from IRA Accounts or Pension Funds to pay premiums without becoming taxable.
   c. This will provide an option to Medicaid as the only alternative to a self funded Long Term Stay and allow spouses to preserve larger portions of their estates.
4. Coverage for people below the poverty level
   a. Have the government purchase a comprehensive Medicare Supplement for individuals at or below the poverty level
   b. This would limit cost to cost of policy ($ 600 to $ 1000 per person per year depending on age and plan)
   c. This would provide a controlled cost rather than an open end liability

Closing

I feel that if the plan that was passed by the House of Representatives became law in its present form, this PLAN would be a catastrophic expense to most Senior Citizens by the year 2000.

John T. Shay

Upper Peninsula Plumbers and Pipefitters
Fringe Benefit Funds Board of Trustees

1219 First Avenue South
Escanaba, MI 49829
August 24, 1987

Karl Numinen.
Senator Reigle Staff
230 Federal Building
Marquette, MI 49855

Dear Karl:

Enclosed is the material on "COBRA" Benefits that I discussed with you at the U. P. State Fair.

Please submit them at the public hearing on Friday August 28th on behalf of our Board.

Thanks!

Sincerely,

Stephen M. Courier.

Stephen M. Courier.
Trustee

Martin J. Gallagher & Company
P.O. Box 5265 · Orchard Lake, Michigan 48033 · (313) 682-7747

August 3, 1987

Mr. Stephen M. Courier
Local Union 506
1219 First Avenue, South
Escanaba, MI 49829

Re: COBRA

Dear Steve:

The other day Tom Reynolds told me you had requested that I send a letter to you outlining some of the problems which will be faced by your Health and Welfare Fund in complying with COBRA (i.e. the "Consolidated Omnibus Budget Reconciliation Act"). Since he also told me that Dave Livingston, T.I.C.'s Director of Research, will also be sending you a letter, I will try to confine my comments in this letter to matters which Dave may not touch upon.

An understanding of the purpose behind COBRA is necessary to understand what a monster has been created. Specifically, the Federal Government wanted to take some of the burden off Medicaid and other subsidized Federal programs by making available some means whereby those who would otherwise lose their coverage under a health care type of program because of layoff, death, divorce, attainment of the age of majority, etc., could continue coverage for a limited period of time by way of self-payments. The social activists behind this program decided that the self-payment rates and/or the coverages would be better if these individuals were allowed to continue their coverage under their employer's group plan (or, in the case of someone other than a laid-off employee, under the group plan sponsored by the employer of the employee upon whose employment their eligibility as dependents was predicated).

The net result of COBRA is to run-up an employer's cost of providing health care coverage to his employees and their eligible dependents in three separate ways.

First of all, COBRA allows an employer or former employer to charge but 2% for the overhead expense of administering the program which is woefully inadequate.

Secondly, it results in poor claims experience for the group program maintained by the employer because the basic facts of the health care industry are that those with a history of illness and/or a large number of dependents are much more likely to continue coverage by voluntary, self-payments than the single, healthy person. This fact, in turn, opens the door to adverse

selection and distorts the assumed group experience upon which the costs of the program was based in the first place.

Thirdly, COBRA allows an individual up to sixty days after a "qualifying event" has taken place within which to elect to continue his coverage and up to an additional forty-five days to make his first payment. This is one of the most absurd features of COBRA! There is no other situation in the entire world-wide insurance industry where one may in effect "purchase" insurance retroactive to cover a claim already incurred. If this were a common practice, every insurance company in the country would be bankrupt. While an argument may be made that an individual may not necessarily know in advance the date his employment will be terminated or the date he may die, any dependent child certainly knows in advance when he will attain age 19, 23, or whatever age the program uses as a cut-off for dependent coverage.

Although it may not be quite a quantifiable cost, it is grossly unfair to stick an employer with the cost of subsidizing continued coverage for a former employee or his dependents when that employee may have only become eligible for but one month at the time a "qualifying event" occurs. Some reasonable period of continued employment should be required before one qualifies for COBRA protection.

Now, let's address the special problem faced by the construction industry in complying with COBRA. Once, again, as with almost all legislation dealing with employee benefits Congress (or those idiots who draft the legislation Congress enacts without understanding it) has passed in recent years, COBRA fails to take into consideration any recognition of the problems inherent in the construction industry.

For some reason or other, Washington just does not understand how employee benefit plans are negotiated or maintained in the construction industry. Our construction industry plans are not negotiated with the employers obligated to pay whatever it costs to maintain them during the term of the collective bargaining agreement. This may be the case for other Unions - but it just cannot work in the construction industry because, by the very nature of the industry, employees regularly move from one employer to another in the course of a year and employers frequently come into and out of existence and may work in or out of the geographical area covered by a Union within the course of a year.

As a result of the foregoing, benefits are not negotiated in the construction industry. Instead a wage package is negotiated and the Union decides the allocation of that wage package among wages and employee benefit plans. If the costs of maintaining a health care plan are increased, the Union members themselves must either reduce their benefits or increase the contributions going into that plan by reducing their base wages. Thus, in the construction industry, the costs of complying with COBRA are not being passed off to the employers but to the Plumber, Carpenter, or Laborer himself. This unfortunate situation is aggravated further when one realizes that, under COBRA, the Union tradesman may be forced to subsidize a former employee who decides to work non-Union and continue his coverage under the

health care plan. This, too, is absurd and further evidence that the unique problems of the construction industry are not understood in Washington.

Steve, I could go on and on about other administrative problems involved in complying with COBRA but I thought I would best stick to some of the philosophical. Should you wish additional comments from me or any elaboration on what I have said, please let me know.

Regards,

Martin J. Gallagher
Consultant

MJG:bjs

RESEARCH DEPARTMENT
TIC INTERNATIONAL CORPORATION

David T. Livingston, Ph.D.
Corporate Director of Research

August 19, 1987

Mr. Stephen M. Courier
Local Union 506
1219 First Avenue, South
Escanaba, MI 49829

Dear Mr. Courier:

In response to a request from Tom Reynolds, I am writing to you to discuss some of the problems which your Health and Welfare Fund will be facing in its efforts to comply with COBRA. Marty Gallagher has sent me a copy of his August 3, 1987 letter to you on the same subject.

I'd like to say at the outset that I concur completely with Marty's observations, especially his comments on the problem of adverse selection and the problems which multiemployer plans in the construction industry will have in meeting the increased benefit costs and increased administrative costs imposed by COBRA.

As Marty so correctly pointed out, "one of the most absurd features of COBRA" is allowing an individual up to 60 days after a qualifying event has taken place to elect COBRA coverage and up to an additional 45 days to pay the first COBRA premium.

The fact is that this elongated election period, coupled with a deferred date for payment of the first premium, is guaranteed to magnify the usual problem of adverse selection which results when self-payments are permitted. With the 60-day election period permitted under COBRA, there is no question that many qualified beneficiaries will hold off until the end of the 60-day period before making a decision as to whether or not they want the COBRA coverage. If they incur substantial medical expenses at any time during that 60-day period or if they discover that they are likely to incur such expenses in the near future, they will undoubtedly elect COBRA coverage before the 60-day period runs out.

The 45-day period for payment of the first premium provides a further incentive for adverse selection because a qualified beneficiary may elect the COBRA coverage and then hold off paying the first premium for up to 45 days. If the qualified beneficiary becomes ill during that 45-day period or discovers that he is likely to incur substantial medical expenses in the near future, then chances are he will pay his first COBRA premium before the

45 days run out. Otherwise, he may drop the COBRA coverage which was previously elected by simply not paying the first premium on time.

As the foregoing indicates, COBRA stacks the deck in favor of persons who want to dump medical expenses onto a group health care plan after the expenses have actually been incurred (or after they know that major medical expenses will be incurred in the near future).

As Marty pointed out: "There is no other situation in the entire world-wide insurance industry where one may, in effect, purchase insurance retroactive to cover a claim already incurred. If this was a common practice, every insurance company in the country would be bankrupt."

The absurdity of the COBRA election period and delayed premium payment period may be illustrated if we think of how these same periods would apply to homeowners insurance. Using "the COBRA principle" one would say to a new homeowner: "Look, why don't you wait for 60 days to see whether or not your house burns down and if it does, just pay us two months back premium and we will cover 80% or more of your losses. Or, if you prefer, just tell us before the end of the next 60 days that you want the homeowners insurance, but don't pay us a cent; wait an additional 44 days to see if you have a fire and if you do, get your premium in by Day 45 and we will still cover 80% of your losses."

What a fantastic deal this would be for the homeowner but of course, no insurance company could afford to operate this way. Yet this is precisely the way the federal government is insisting that group health care plans operate with respect to providing health insurance to a select group of beneficiaries!

To make matters even worse, one of the technical amendments to COBRA allows qualified beneficiaries to wait for up to 60 days before notifying the plan administrator about certain qualifying events such as a divorce, a legal separation, or the failure of a child to meet the plan's definition of a "dependent child." In effect, a qualified beneficiary gets an additional 60 days up front to wait and see if major medical expenses are incurred before triggering the 60-day election period.

This delayed notification requirement is also absurd. A divorcee certainly knows what the date is on the divorce decree. Similarly, a spouse who is legally separated from a covered employee knows what date appears on the separation papers. Also, the employee or spouse knows the age of each child in the family and should know when each child no longer meets the age requirement for dependent coverage under the plan. Why should COBRA allow 60

days to report any of these dates to the plan administrator, thus greatly enhancing the potential for adverse selection?

Apparently, various women's interest groups who were among the main backers of COBRA were able to convince many Congressmen and Senators that they needed special treatment and that's exactly what they got --- special treatment! Employers were not so lucky as evidenced by the fact that COBRA gives employers only 30 days (not 60 days) to notify the plan administrator about certain qualifying events such as a reduction in hours worked or termination of employment. Clearly, this was a political decision and one specifically designed to give certain qualified beneficiaries, notably divorcees and dependent children, an extra opportunity to dump their medical expenses on group health care plans while retaining their right to purchase health care coverage at group rates. Such a deal!

As if this deal wasn't good enough, the IRS in its recently proposed COBRA regulations decided to "add a sweetener" by permitting a qualified beneficiary who waives COBRA coverage at any time during the 60-day election period to change his or her mind and revoke the earlier waiver before the end of the election period. Although a plan may begin the COBRA coverage as of the election date rather than as of the date of the qualifying event if there is a revocation of an earlier waiver, this does nothing to prevent adverse selection; in fact, it just intensifies the adverse selection problem.

The fact is that the qualified beneficiary who changes his mind after initially waiving COBRA coverage will be the one who has discovered that substantial medical expenses are likely to be incurred in the near future and he will view his chance to change his earlier waiver of COBRA coverage as a grand opportunity to unload those medical expenses onto the plan by signing up for COBRA coverage.

For example, assume that Joe rejects COBRA coverage on Day 40 of the 60-day election period. On Day 58 of the same period, Joe's doctor tells him that he will need a triple bypass and that it should be done within the next month or two. Bingo! On Day 59, Joe notifies the plan administrator that he has changed his mind about COBRA coverage and would now like to purchase such coverage. Once again, the qualified beneficiary wins and the plan loses!

Incidentally, our firm recommended in its comments on the proposed IRS regulations that qualified beneficiaries be limited to a one-time election decision during any 60-day election period. Although this would not solve the adverse selection problem because a qualified beneficiary could still hold off to the end of

the election period before electing COBRA coverage, at least the regulations would not aggravate the problem.

In addition, imposing a one-time election requirement would reduce the administrative burden. If the IRS proposed regulations are not changed on this subject, plans will have to set up special recordkeeping systems just to monitor the changes in election choices and they will also have to send out revised premium payment schedules if the coverage begins with the election date rather than the date of the qualifying event. (For further details on these problems, see pages 9-13 of our submission to the IRS which is enclosed.)

There is no question that adverse selection will add significantly to the benefit costs of most group health care plans. Unfortunately, those increased costs will not be readily recoverable (in fact, it is more likely that they will never be recoverable) from the COBRA premium charge. First of all, there will always be a time lag between the time the expenses are incurred and the time at which the COBRA premium can be adjusted. The proposed regulations specifically prohibit the adjustment of a COBRA premium more than once every 12 months so, in effect, a fund is always in the position of trying to play catch-up with the benefit cost increases generated by adverse selection.

In addition, the IRS has made it quite clear that plans may not base the COBRA premium solely on the claims experience of COBRA beneficiaries but may only base the premium on the costs of providing the same coverage to similarly situated beneficiaries under the plan.

What this means is that the health care costs for those who have elected COBRA coverage will be understated because they must be blended in with the health care costs of all other employees covered under the plan, most of whom are probably in good health because they are actively employed. Consequently, the COBRA premium will never be adequate to meet the actual costs of providing coverage to COBRA beneficiaries who are likely to include a much higher percentage of persons with serious illnesses. In other words, it's a no-win situation!

There will only be one way for many plans to meet the increased benefit costs and that will be to reduce the benefits provided to active employees and/or retirees or to postpone benefit improvements that may have been under consideration. If a plan is sponsored by a single employer, it may be possible for that employer to pass along some of the increased cost by raising the price of his goods or services but even that may not be a viable option if

the employer already finds himself in a highly competitive position and as a result, cannot increase prices.

For our multiemployer plans, this option is unavailable for the simple reason that employers are locked into a collective bargaining agreement which may not expire for two years, three years, four years, or even longer. As a general rule, an employer is not going to renegotiate such an agreement before the expiration date in order to meet any increased costs of operating the group health care plan(s) to which he contributes. As a result, the trustees of the multiemployer plan will have no choice but to reduce benefits for active employees or retirees which, in turn, will mean a reduction in benefits for their COBRA counterparts.

This is a dim prognosis of what the impact of COBRA will be on our types of plans, especially those covering workers in the construction industry, but the fact remains that there is only so much money coming into the fund during any period covered by a collective bargaining agreement and if expenses outpace revenues, something has to give and benefit reductions seem inevitable.

Unfortunately, when the Congress and the Senate considered COBRA, they did so without any information whatsoever as to what the increased benefit costs and administrative costs would be if COBRA was adopted. In fact, there were no public hearings on COBRA because this piece of legislation was tacked onto a budget reconciliation bill at the ninth hour and got passed before the public-at-large had any idea that COBRA was in the legislative hopper. As a result, plan sponsors and professional advisors serving group health care plans never had any opportunity to comment on the adverse consequences that COBRA would have on benefit costs and administrative costs and how these costs could not be recovered in most cases through the COBRA premium charge.

It is a sad commentary on the federal legislative process when legislation can be proposed and adopted without any consideration being given to its impact on employer costs and on employment opportunities. We might very well see a repeat of this phenomenon during this session of Congress. Already tucked away in the House Ways and Means Committee's 1988 omnibus budget bill is a provision which would permit states to require employers with 20 or more employees to fund the losses sustained by state risk pools for the uninsureds and the uninsurables. If an employer fails to pay the state assessment for the risk pool, the state may then impose a penalty equal to 5% of that employer's gross payroll.

What is so disturbing about this proposal is that no one, least of all the plan sponsors, has the foggiest notion of what the employer costs will be if this proposal is adopted!

It should be noted, however, that a number of states already have risk pools for the uninsurables and in 10 or the 12 states, the premiums charged for the coverage have been insufficient to finance even half of the total cost so employers have had to make up the difference. Consequently, every employer legitimately fears that if the House Ways and Means proposal is adopted, they will be saddled with substantial costs of unknown magnitude.

Unfortunately, we seem to have reached a point where some Congressmen and Senators just don't give a damn what it costs the employer when either the federal government or a state government mandate health care benefits. What is happening is that sponsors of this type of legislation are being overly responsive to various interest groups which are demanding that the federal government do something to meet the health care needs of certain special groups. Some Congressmen and Senators have learned from the COBRA experience that they can respond to these demands from special interest groups without having it cost the federal government a cent; all they have to do is to require existing group health care plans or employers to foot the bill if premiums fall short. When this is done, it costs the federal government absolutely nothing and it probably will gain important votes when the 1988 elections roll around!

This is very short-sighted thinking because employers cannot continue to absorb these mandated health care costs without making some major adjustments in their group health care programs in the form of benefit reductions. Unless Congressmen and Senators wake up soon to the fact that they cannot solve all of the nation's health care needs by loading requirement after requirement onto existing group health care plans without any consideration of employer costs, the level of health care protection currently provided to the active worker and to retirees is bound to suffer.

There is, however, some recent recognition in the Senate that employer costs should be given serious consideration when any bill mandating employee benefits is proposed. This is evidenced by the fact that on July 14, 1987, a Senate resolution was attached to a trade bill (S 1420) which, if the trade bill is ultimately adopted, will require any Senate committee that favorably reports out any bill mandating employee benefits to include with the bill "an objective analysis of the impact of the bill on employers (especially small businesses), the economy (in terms of international competitiveness), and employees (in terms of conditions of employment)."

Although this amendment to the trade bill is considered to be non-binding, it will, nevertheless, be difficult for Senate committee members to ignore if the trade bill is adopted and it will help to focus legitimate attention on the cost implications of federally mandated benefit proposals.

A similar resolution is pending before the House Rules Committee (House Resolution 188) with 56 cosponsors. I notice that the only Congressman from Michigan who is listed to date as a cosponsor is Representative Henry. Every Michigan Congressman should be supporting this resolution requiring "each House committee that reports legislation that requires employers to provide new employee benefits to secure an objective analysis of the impact of the legislation on employment and international competitiveness and include an analysis of the impact in the report of the committee on legislation." At the very least, this resolution may help to preclude another COBRA which was voted into law without any understanding of its cost implications.

Of course, substantial increases in benefit costs due to adverse selection are not the only thing we need to be concerned about with COBRA, but also the increased administrative costs due to the vast array of new administrative tasks which have to be performed in order to satisfy the COBRA requirements.

These new administrative tasks include, but are not limited to: sending out an initial notice to all participants and retirees describing their rights to COBRA coverage; detecting qualifying events as soon as possible after their occurrence; sending out election notices within 14 days after a qualifying event; properly recording election choices; carefully monitoring COBRA coverage periods to make sure maximum limits are not exceeded; compiling pertinent claims data for determining the applicable COBRA premium or premiums; detecting those events which permit the cancellation of COBRA coverage as soon as possible after their occurrence; sending out cancellation notices on time; and handling the numerous inquiries from participants and retirees which are bound to arise due to the complexity of the law's requirements.

Some of these tasks will be especially burdensome. For example, preparation of the election notice seems likely to be quite time-consuming. Although the format and the wording of the notice may be standardized to some extent, much of the information included in the notice must be keyed to the specific qualified beneficiary to whom the notice is being sent including the reason why COBRA coverage is being offered, the amount of the retroactive premium, the amount of the monthly premium after the retroactive premium is paid, the number of months for which COBRA coverage may be purchased, an explanation of any offsets already made against the

maximum period of COBRA coverage the plan has to offer, and the date on which the election period ends.

Major changes in recordkeeping systems will be required in order to properly record and monitor the election choices. COBRA gives qualified beneficiaries a number of coverage choices that the typical multiemployer plan does not currently provide to an active employee or retiree and this will greatly complicate the recordkeeping system. For example, if a plan has dental and vision care coverages, these coverages may automatically be included in the benefits provided to an active employee. Under COBRA, however, a qualified beneficiary must be given the right to exclude these so-called "non-core" benefits from the benefit package and to purchase only the basic hospital and surgical benefits provided under the plan (so-called "core" benefits) in order to reduce the COBRA premium. Consequently, COBRA beneficiaries have choices not available to active employees and the recordkeeping system has to be redesigned to properly record these choices just for COBRA beneficiaries.

A further complication arises if the employee decides not to elect COBRA coverage for the entire family. If this occurs, then each member of the family (except for minor dependent children) must be given the right to individually elect COBRA coverage and further to choose between core benefits only or core plus noncore benefits. For example, the spouse may elect core coverage only for herself and perhaps several of the dependent children but because one of the children needs some extensive dental work done in the near future, she may opt for core plus noncore benefits for that particular child. As this example illustrates, the range of election choices which COBRA requires will add considerably to the recordkeeping burden; especially, when you stop to consider that none of this recordkeeping had to be done prior to COBRA.

This burden will become even heavier if the IRS insists in its final regulations that plans permit qualified beneficiaries to change their election choices as many times as they want to during any given 60-day election period!

Applying the appropriate offsets against the required COBRA coverage periods will also be a new administrative task. No plan wants to provide COBRA coverage for any longer period of time than the law requires. Consequently, when multiple qualifying events occur (e.g., the death of a covered employee or divorce from a covered employee when the covered employee has purchased COBRA coverage), a plan must have appropriate recordkeeping procedures in place to "red flag" this earlier COBRA coverage so that it may be used as an offset against the 36 months of re-

quired coverage. As a matter of fact, this is one of the few things that a plan can do to minimize its COBRA benefit costs.

A plan should also do whatever it can to detect as early as possible when a qualified beneficiary is covered under any other group health care plan because if there is coverage under another group health care plan, then COBRA coverage does not have to be provided in the first place or it may be cancelled if it is already in effect. In that regard, some plans are including a questionnaire with the election notice which asks questions about whether or not any member of the family is employed and if they are employed, whether or not they have coverage under their employer's group health care plan. If other coverage is discovered, then COBRA coverage (even if elected) does not have to be provided. *Use of such procedures will be critical if a plan expects to gain any control over its COBRA costs. Yet implementation of such procedures will require an extra administrative effort and is bound to add to administrative costs.*

Still another heavy administrative burden will be the handling of inquiries and complaints from qualified beneficiaries. The election notice itself will probably spark numerous inquiries no matter how well-written the election notice appears to be. The fact remains that some qualified beneficiaries are not going to understand when the first premium is due, why the first premium is so much higher than subsequent premiums due to retroactive coverage, why they can't purchase just non-core benefits, or why previous COBRA coverage was used as an offset. The fact is that COBRA is a very complex law and this complexity, in and of itself, makes it virtually impossible to translate the law's requirements into language which the average participant or retiree can understand.

It seems likely that complaints will be a common occurrence. For example, I think there will be complaints from divorcees or dependent children who contend that they never received the initial COBRA notice and, therefore, were unaware of their obligation to notify the fund office within 60 days after the divorce or after the dependent child lost his or her status as a dependent child under the terms of the plan. They may argue that had they known about this requirement, they would have notified the fund office within the required 60-day limit because they wanted to purchase COBRA coverage. Or, a plan may receive complaints from spouses who contend that the covered employee never showed them the election notice and, therefore, they were unaware that they had the right to individually elect COBRA coverage after the covered employee rejected such coverage for the entire family.

Complaints about the COBRA premium being too high also seem likely, especially if there is a sizable retroactive premium.

In many instances, the retroactive premium may go back 2, 3 or even four months and could easily fall into the $500 to $1,000 range. Such a premium is bound to elicit a critical inquiry from the qualified beneficiary.

The point is that the fund office will be bombarded with many COBRA-related inquiries and these inquiries will have to be handled in a timely and diplomatic way. This activity alone will place a tremendous demand on the amount of time which fund office staff must allocate to COBRA-related matters.

As the preceding discussion indicates, the implementation of the COBRA requirements is a gigantic administrative undertaking and there are no quick-and-easy shortcuts. I seriously doubt that those who drafted the law had any understanding of the administrative complexities and problems that COBRA would create. They certainly had no understanding of the increased administrative costs that the COBRA requirements would impose on every group health care plan as evidenced by the 2%-of-premium limit placed on the overhead expense of administering the COBRA program. This limit is totally unrealistic and the only way to cope with the increased administrative costs which cannot be recovered from the COBRA premium charge will be to reduce benefits for active employees and retirees and/or to hold the line on any benefit improvements.

Unfortunately, the chances of getting needed corrective amendments to COBRA in the foreseeable future are probably not very good. Most Congressmen and Senators will be reluctant to make any fundamental changes in COBRA until they have some hard evidence that the adverse consequences predicted by so many critics of the legislation have actually occurred. Of course, by that time, a great deal of damage may already have been done in terms of COBRA generating benefit costs and administrative costs which are non-recoverable.

Meanwhile, we should not sit quietly on the sidelines waiting for this to occur, but rather should do whatever we can through our own political contacts to get certain COBRA amendments introduced and adopted as soon as possible including amendments which would: (1) reduce the election period from 60 days to 15 days; (2) reduce the time allowed for notification to the plan administrator regarding a divorce, legal separation, or change in the dependent status of a child from 60 days to 30 days; (3) reduce the grace period for payment of the retroactive premium from 45 days to 30 days (consistent with the grace period for all subsequent premiums); and (4) permit a plan to add on up to 10% (rather than 2%) of the costs used to determine the COBRA premium to cover the additional administrative costs generated by the COBRA requirements. Such amendments would go a long way toward reducing (but not eliminating) the potential for adverse selection and toward

developing a COBRA premium which properly reflects the true costs of administration.

Incidentally, in February of 1987, one of your Michigan Congressmen, Mr. Henry, introduced several COBRA amendments which merit serious consideration and deserve the full support and endorsement of Michigan's other 17 Congressmen. Henry's bill (H.R. 1072) would impose a minimum service requirement as a condition for COBRA coverage. An employee would have to be "eligible for coverage under the plan for at least 90 consecutive days" before he could qualify for COBRA coverage if there was a qualifying event.

This makes a lot of sense because a plan should not have to subsidize the cost of continuation coverage for short-term employees who only have a temporary working relationship with a contributing employer. Right now under the eligibility rules of some multiemployer plans, an employee may gain initial eligibility after just one month of employment and if he loses his eligibility for coverage the following month due to a reduction in hours worked, he would immediately qualify for COBRA coverage. There is a real potential for abuse here because an employee may have no intention of continuing to work for a contributing employer yet is able to obtain COBRA coverage for up to 18 months and to immediately dump substantial medical expenses on the plan.

This situation seems even more unfair if this same short-term employee walks down the street after just one month of employment for a contributing employer and goes to work for a non-union employer who has no health care plan at all. In effect, the union employer and the union employee end up subsidizing a former employee who decides to work non-union and the non-union employer enhances his competitive edge by not having to provide any health care coverage at all!

At any rate, the minimum service requirement proposed by Congressman Henry is a move in the right direction. It would at least place some reasonable restraint on the potential for abuse by short-term employees. Henry has also proposed that plans be permitted to cancel COBRA coverage as soon as a COBRA beneficiary "becomes eligible" for coverage under another group health care plan.

The way COBRA is currently written, COBRA coverage may be cancelled only if a qualified beneficiary is actually covered (and is not just eligible for coverage) under another group health care plan. Even though eligibility for coverage under an other group health care plan may be difficult to detect, there is no reason why a plan should be required to offer COBRA coverage to a former employee when that employee is eligible for coverage under a new employer's health care plan but decides against participating in the new employer's plan. It is simply unfair to saddle

a former employer with health care costs that should fall on the new employer. If the employee wants to go to work for a new employer whose health care benefits are less extensive or less valuable than those provided by the old employer, that is a personal decision which has to be made by the individual employee. Once an employee makes the decision to sever his employment relationship with a former employer, that former employer should have no legal obligation to provide any benefits once the employment relationship has ended.

It should be noted that the proposed amendments described above are now languishing in the committees on Education and Labor, Energy and Commerce, and the House Ways and Means Committee and no hearings on H.R. 1072 have yet been scheduled. If there is any influence which you can wield, Steve, to get this bill up for serious consideration, I hope that you will get actively involved. Incidentally, it would be helpful if your two Michigan Senators would introduce the same bill in the Senate and would push for early committee action in the Senate.

Although H.R. 1072 offers no solution to the most critical problem created by COBRA, namely the problem of adverse selection, adoption of H.R. 1072 and its Senate counterpart might at least get the ball rolling toward serious consideration of other needed COBRA amendments (such as the four amendments mentioned earlier).

I notice that I have become long-winded in this discussion of COBRA problems, but frankly, what I have discussed in this letter only scratches the surface of the numerous administrative problems and cost problems which every group health care plan will have to come to grips with in their COBRA compliance efforts. I hope, however, this information will be useful as you go about the business of making important trustee decisions related to COBRA compliance.

If you would like to discuss other compliance problems that may not have been touched upon in this letter or would like additional information about topics covered in this letter, don't hesitate to ask.

Sincerely yours,

David T. Livingston, Ph.D.
Vice President and Director
of Research

DTL:nv

cc: M. Gallagher
T. Reynolds

RESEARCH DEPARTMENT
TIC INTERNATIONAL CORPORATION

David T. Livingston, Ph.D.
Corporate Director of Research

August 10, 1987

Mr. Mark Schwimmer
Employee Plans and Exempt
Organizations Division
Office of the General Counsel
Internal Revenue Service
1111 Constitution Avenue, N.W.
Washington, D.C. 20224

ATTENTION: CC:LR:T

Dear Mr. Schwimmer:

The purpose of this letter is to submit comments on the proposed COBRA regulations along with some suggestions for change and further clarification of the proposed regulations. A SUMMARY OF OUR MAJOR RECOMMENDATIONS APPEARS ON PAGES 18-20.

First of all, I would like to commend you, Mike Thrasher, and others who worked so diligently on this set of COBRA regulations for producing a text that is well-organized, is written in English and not in legal jargon, and is, for the most part, understandable.

Developing this first set of COBRA regulations must have been a horrendous assignment given the complexity of the law itself and the many questions it left unanswered. Nevertheless, you seemed to have picked up the gauntlet with great determination and have produced a set of regulations which do provide many clarifications of the basic COBRA requirements.

It would be unreasonable, however, to expect this first run of COBRA regulations to provide all of the clarification that those serving as professional advisors to group health care plans might expect. Consequently our firm, which provides administrative and consulting services to hundreds of multiemployer health care plans, appreciates this opportunity to point out certain areas where further clarification is necessary as well as several areas where we feel a basic change in a particular regulatory requirement would be appropriate.

As Director of Research for TIC International, I have had extensive conversations with our administrative managers and consultants about the COBRA regulations as well as with trustees of our multiemployer health care fund clients.

As a result of these discussions, I think that what I have to say is fairly representative of many of the concerns that those working with multiemployer health care plans have about the COBRA requirements.

Unfortunately, those who drafted the COBRA requirements seemed to have only single employer plans in mind and did not foresee some of the adverse consequences that some requirements would have for multiemployer plans. In the discussion which follows, I have tried to focus on these adverse consequences and have made some suggestions as to how these consequences might be minimized by regulation (see especially pages 2-5).

My comments are keyed to the answers to specific questions in the regulations including the answers to Questions: 3 --- Sanctions; 17 --- Coverage of New Family Members; 35 --- Right To Change Election Choices; 38 --- Coverage Under Another Group Health Care Plan; and 45 --- Frequency of Premium Changes.

QUESTION 3: IRS SANCTIONS

The answer to this question indicates that if any group health care plan maintained by an employer is not in compliance with COBRA, that employer may lose the tax deductibility of the contributions which he has made during the taxable year(s) of noncompliance to any group health care plan maintained by the same employer.

This penalty borders on "cruel and unusual punishment!" Although the denial of a tax deduction for employer contributions is a proper sanction for encouraging full compliance with the COBRA requirements, it is doubtful that the application of this sanction to all contributions made by the employer to any group health care plan which he maintains is really necessary to achieve that objective. Indeed, it is legitimate to ask: "Why wield a club when a small stick would do?"

This sanction would be especially harsh if it is applied to an employer who participates in a multiemployer health care plan because an individual employer is often contributing to a number of different multiemployer plans over which he has virtually no control. Once the contributions are made, a board of trustees on which labor and management are equally represented make all of the decisions with respect to management of the plan and the trustees of each fund bear the primary responsibility for assuring compliance with the COBRA requirements.

One of the major problems created by COBRA has been (and will continue to be) that it has generated considerable divergency of opinion among boards of trustees and among their professional advisors as to what must be done to comply with COBRA. This is not surprising given the complexity of the law itself, the long delay before any regulations were even proposed, and the fact that plan administrators still have no regulatory guidance regarding COBRA's premium determination and notification requirements.

Given these circumstances, it is quite possible that an individual employer may be contributing to a multiemployer plan which is not in full compliance with all of the COBRA requirements while, at the same time, he will be contributing to any number of other multiemployer plans which are in full compliance with COBRA. Yet, under the proposed regulations, the IRS could remove the tax deductibility for his contributions to all of the plans in which he participates. Indeed, the sanction imposed on an individual contributing employer for the non-compliance of one plan in which he participates would be just as severe as it would be if none of the plans to which the employer was contributing were in compliance.

In the situation described above, it appears that the severity of the punishment far exceeds the gravity of the crime and it is not surprising that many employers who are contributing to multiemployer group health care plans are "on edge" about this greatly expanded tax liability.

In fact, our firm has received numerous inquiries from employers who contribute to multiemployer health care plans which we administer wanting to know what their tax liability would be in the event that just one of the plans to which they contribute might fall short in its COBRA compliance efforts. We have told them that under the proposed regulations, there is the possibility that even if only one plan to which they contribute is not in compliance, they may lose their deductibility for all contributions made to any group health care plan during the year of non-compliance. Their reaction to this explanation is what you would expect: one of total disbelief! Moreover, our firm cannot provide any rational explanation nor is any explanation provided in the regulations as to why the tax sanction is so onerous.

Another related concern here is that if such a tax sanction may be applied for COBRA purposes, may it also be applied for violations of any other federal laws applicable to group health care plans?

Frankly, I think the IRS has really gone over-board here with respect to applying such stringent sanctions for COBRA purposes. As one analyst of the proposed regulations commented to me: "What the IRS seems to be doing here is rolling out a cannon just to kill a fly!"

I would like to urge the IRS to consider a more limited application of the tax disallowance sanction, namely to apply the sanction only to those employer contributions which have been made to a specific plan (or plans) which are not in compliance with COBRA.

It seems most unlikely that any employer (a single employer or an employer participating in a multiemployer plan) would want to lose the tax deductibility for any of the contributions which he makes to any group health care plan. Consequently, this more limited application of the tax disallowance sanction should be more than adequate to achieve a good faith effort toward compliance on the part of every group health care plan.

Even under this more limited application of the tax disallowance sanction, many employers (both single employers and those contributing to a multiemployer plan) will be legitimately concerned about the conditions under which this sanction would be exercised.

The present wording of the proposed regulations leaves the impression that even a minor violation of the COBRA requirements (i.e., a single mistake involving a single beneficiary on a single day) would be sufficient for the IRS to initiate the tax disallowance sanction.

Such an application of the tax disallowance sanction seems grossly unfair if the plan has made a good faith effort to assure compliance. As you know, COBRA is an extremely complex law and despite the issuance of your recent regulations, there will continue to be varying interpretations of what the law requires. Moreover, in one of the most critical areas of COBRA compliance, namely premium determination, plans have been given no regulatory guidance at all and none is expected for several months.

Because of the factors cited above, it seems inevitable that some plans will make honest mistakes in their COBRA compliance efforts and such plans should be given a reasonable opportunity to correct those mistakes without plan sponsors suffering any loss of tax deductibility for their contributions.

As a general rule, the mistakes will be unintentional and will be based on a misinterpretation of a particular COBRA requirement or will involve a clerical error or omission (such as failing to send an election notice out on time or posting of an inappro-

priate premium on the payment schedule). In most cases, these mistakes can be immediately corrected by the plan without any loss being sustained by a qualified beneficiary. For example, if COBRA coverage should have been offered and was not, and if medical expenses were incurred during the period when COBRA coverage could have been in effect, a plan might simply be required to reimburse the qualified beneficiary for such expenses.

The point is that in most instances a COBRA violation can be, and will be, remedied by the plan administrator as soon as the violation is discovered. As a result, it will serve no useful purpose whatsoever if the IRS comes along and applies the tax disallowance sanction. In fact, application of the tax disallowance sanction will be of no benefit at all to a qualified beneficiary. The only thing the sanction would do is generate some federal revenue and that certainly should not be the primary purpose of applying this sanction!

For the reasons just cited, I think it would be a move in the right direction if the IRS were to place some reasonable limits on its authority to apply the tax disallowance sanctions when COBRA violations are discovered. In that regard, I'd like to suggest that wording be added to the answer to Question 3 indicating that it is NOT the intent of the IRS to apply the tax disallowance sanction to every violation of COBRA, and the sanction would not be used if a plan can demonstrate that: (1) it has made "a good faith effort" at compliance; (2) that the violation was unintentional; and (3) appropriate corrective action has been taken to remedy the violation.

A provision of this type, clearly stated in the regulations, would go a long way toward allaying current employer fears that the IRS will be running around like a loose cannon firing its tax disallowance salvos at any employer who falls short of 100% COBRA compliance!

QUESTION 17: NEW FAMILY MEMBERS

The answer to this question is extremely important because it sets needed limits on when COBRA coverage must be extended to new family members and when new family members may or may not become qualified beneficiaries.

If my reading of your answer to Question 17 is a correct one, I would like to indicate my support for the limits which the regulations place on COBRA coverage for new family members. However, I would also like to suggest a few changes designed to provide further clarification.

The answer to Question 17 makes it quite clear that new family members who join the family after the covered employee has first purchased COBRA coverage do NOT become qualified beneficiaries when a subsequent qualifying event occurs, such as the death of the employee or a divorce, even if they become eligible for COBRA coverage prior to the subsequent qualifying event.

Further, the answer to Question 17 indicates, by a cross reference to Question 30(c) and 31, that it is NOT necessary to extend COBRA coverage to a new spouse or to new children UNLESS:

(1) the plan rules provide for the automatic extension of coverage to the new spouse or new children of a covered employee who has not lost his coverage under the plan,

- OR -

(2) the plan rules provide for an open enrollment period during which the new spouse or new children may be "added on" to the employee's health care coverage.

Since these two conditions are the critical determinants of whether or not a plan is required to extend COBRA coverage to new family members, I would like to suggest that these two conditions be specifically stated in the answer to Question 17 rather than merely alluded to in the answer to Questions 30(c) and 31.

With one exception, I found the examples cited in the answer to Question 17 quite helpful in clarifying when COBRA coverage must be extended to new family members and when new family members do not become qualified beneficiaries. However, Example 3 concerning a dependent child has created considerable confusion as evidenced by the fact that various fund counsel and fund consultants with whom I have discussed this example are coming away with different interpretations of when COBRA coverage must be extended to new family members of a former dependent child who has purchased COBRA coverage. This is too critical a matter to leave room for individual interpretations and further clarification is essential.

Example 3 makes it clear that if a dependent child ceases to meet the plan's definition of a dependent child, then COBRA coverage must be offered to the former dependent child. The example also makes it clear that the new spouse and new children of that former dependent child would not become qualified beneficiaries in the event of the former dependent child's death or divorce.

What is not clear, however, in the narrative of Example 3 is whether the COBRA coverage purchased by the former dependent child would, under any circumstances, have to be extended to the new spouse or new children of that former dependent child.

I assume that even though the former dependent child purchased COBRA coverage, such coverage would NOT have to be extended to the new spouse or new children of the former dependent child UNLESS the plan rules would have extended coverage to the spouse or children of a dependent child prior to the qualifying event (i.e., prior to the failure of the child to meet the plan's definition of a dependent child). If the plan rules prior to the qualifying event did not provide for the coverage of a dependent child's spouse or children, either as the result of an automatic extension of coverage or an open enrollment period, then I assume that no continuation coverage would have to be offered after the qualifying event.

This conclusion would seem to be perfectly consistent with the rules applicable to active employees and their new spouses and new children. The new spouse and new children of an active employee are eligible for COBRA coverage after the qualifying event (i.e., a reduction in hours or a termination of employment) only if the plan rules allow for extension of coverage to the new spouse or new children of an active employee prior to the qualifying event.

Similarly, the new spouse or new children of a dependent child would be eligible for COBRA coverage after the qualifying event (child's loss of coverage due to his or her failure to meet the plan's definition of a dependent child) only if the plan rules specifically provide for the coverage of a dependent child's spouse or children prior to the qualifying event.

Under the plan rules of most multiemployer plans, coverage is automatically extended to the new spouse or new children of an active employee but most plan rules specifically exclude any coverage for the new spouse or new children of a dependent child. If COBRA coverage had to be provided to the new spouse or new children of a dependent child, such a requirement would create a whole new group of beneficiaries who were never previously entitled to coverage under the plan rules. This result would appear to be totally inconsistent with the congressional intent which is to provide continuation coverage to certain persons who previously had coverage under the plan and then lost it (due to a qualifying event). It was not the congressional intent to force plans to extend coverage to new groups which never would have qualified for coverage under the plan in the first place.

It should be noted here that there are a few multiemployer plans (notably those with coverage through the Blues) which provide coverage to a dependent child even though he or she marries and also automatically extend coverage to the new spouse or new child of the married dependent child if the dependent child is still receiving 50% or more of his support from his parents. In this situation, if coverage of the new spouse or new children was in effect at the time the dependent child ultimately lost his status as a dependent child under the plan rules, then COBRA coverage should be offered to the entire family because the entire family was covered under the plan at the time of the qualifying event.

The important point here is that if the plan rules result in the coverage of the new family members of a dependent child prior to the qualifying event, then COBRA coverage should be extended to the entire family when the qualifying event occurs but if the plan rules preclude coverage of the new family members of a dependent child prior to the qualifying event, then COBRA coverage should only have to be offered to the dependent child if he or she fails to meet the plan's definition of a dependent child and should not have to be offered to the other family members at any time.

If the IRS agrees with this conclusion, then I would suggest that the wording under Example 3 be changed to read as follows:

> Assume that under the terms of a group health care plan, a covered employee's unmarried child ceases to be a dependent child eligible for coverage upon attaining age 18. At that time, the child must be offered an opportunity to elect COBRA coverage.
>
> Assume further that the former dependent child purchases COBRA coverage and while the COBRA coverage is in effect, he marries. The new spouse or any new children may or may not be eligible for COBRA coverage depending on the plan rules.
>
> If the plan rules normally extend coverage to the new spouse or new children of a dependent child, either automatically or as the result of an open enrollment period, then such new family members are eligible for COBRA coverage. However, if they elect COBRA coverage, the plan may charge a higher premium for the extended coverage.
>
> If the plan rules do not provide for coverage of the new spouse or new children of a dependent child prior

> to the dependent child's loss of coverage under the plan, then the new spouse and new children of a former dependent child are not entitled to COBRA coverage.

This proposed example should go a long way toward clarifying the conditions under which the new family members of a dependent child must be extended COBRA coverage. I would also like to suggest the addition of an Example which would deal with the same issue as it relates to the new spouse or new children of a divorcee.

A question which is bound to arise (and one which is not addressed in the regulations but should be) is whether COBRA coverage purchased by the divorcee must be extended to the new spouse, if he or she remarries, or to previous children of the new spouse, or to any children born after the remarriage.

I assume that the same principle would apply here as would apply to the dependent child, namely that COBRA coverage would have to be extended only if coverage would have been extended to such persons under existing plan rules prior to the qualifying event (in this case, prior to the divorce). Since most plan rules would not extend coverage under any condition to a divorcee's new spouse or new children, then there would appear to be no reason to extend COBRA coverage either.

Again, this is a matter which should not be left open to varying interpretations and the best way to avoid that possibility would be to include a specific example in the final regulations dealing specifically with the divorcee who remarries.

QUESTION 35: RIGHT TO CHANGE ELECTION CHOICES

One of the major concerns about COBRA is the high probability that a plan's benefit costs will increase significantly due to the fact that the COBRA requirements encourage adverse selection. The answer to question 35 which gives the qualified beneficiary the right to change his election or waiver of COBRA coverage as many times as he wants to during the 60-day election period heightens this concern because it will provide an additional incentive for adverse selection.

As you know, COBRA is purposely designed to provide many incentives for adverse selection including 60 days to report certain qualifying events to the plan administrator (such as divorce, legal separation, a change in the dependent status of a child), 60 days to make the initial COBRA election, and another 45 days

to pay the first premium. These are among the most absurd features of COBRA because they violate basic insurance principles.

There is no other situation in the entire world-wide insurance industry comparable to COBRA which, in effect, permits one to "purchase" insurance which is retroactive to cover claims already incurred. If this same principle was applied to all forms of insurance, every insurance company in the country would be bankrupt in a relatively short period of time.

Under COBRA, there is a high probability that those most likely to purchase continuation coverage will be those who are seriously ill or those who have been recently diagnosed as having a serious illness and anticipate substantial medical expenses in the near future. The ultimate effect of the COBRA right to buy health insurance to cover major medical expenses already incurred or major medical expenses likely to be incurred will be to significantly increase any plan's benefit costs.

Unfortunately, these increased benefit costs, attributable solely to the adverse selection, cannot be recovered over the short run because the COBRA premium may be changed only once every 12 months. Moreover, since COBRA prohibits the COBRA premium to be based solely on the cost of providing health care to COBRA beneficiaries alone but rather requires the premium to be based on the cost of providing health care to all similarly situated beneficiaries which normally would include many healthy individuals and families, the COBRA premium will always fall short of covering the actual cost of health care services for COBRA beneficiaries.

For many plans, and this is especially true for multiemployer plans, the only way to pay for the increased costs attributable to the adverse selection by COBRA beneficiaries will be to reduce the benefits provided to active employees and/or retirees or to hold the line on any benefit improvements.

In a multiemployer plan situation, increased funding from contributing employers to help meet these increased costs is almost never a viable alternative between collective bargaining periods. Contributing employers have already signed a collective bargaining agreement for a year, two years, three years, or even longer and they are not likely to renegotiate an agreement before its expiration date in order to cope with the cost impact of adverse selection. As a result, the trustees of some multiemployer plans will be facing some tough choices about benefit reductions once COBRA is in place.

Meanwhile, the last thing that the trustees of a multiemployer health care plan want to see happen is to have the adverse selection process given any further encouragement. Yet this is precisely what the answer to Question 35 does by giving a qualified beneficiary the right to change his or her election of COBRA coverage as often as he or she wants to during the 60-day election period.

Although the regulations provide that if the COBRA coverage is first waived and then later elected, the plan may elect to provide coverage back to the election date and not back to the date of the qualifying event, this procedure offers virtually no protection against adverse selection. The fact is that the qualified beneficiary who changes his or her mind after the initial waiver of COBRA coverage will be the one who has discovered that substantial medical expenses are likely to be incurred sometime in the near future and he will use the second chance to elect COBRA coverage as a grand opportunity to unload major medical expenses onto the plan.

For example, let's assume that Joe rejects COBRA coverage on Day 40 of the 60-day election period. On Day 58 of the same period, Joe's doctor tells him that he will need a triple bypass and that it should be done within the next month or two. Bingo! On Day 59, Joe notifies the plan administrator that he has changed his mind and would now like to purchase COBRA coverage. Not only has Joe been given another opportunity to transfer medical expenses to the plan but the plan has lost out on several months of retroactive premium if coverage begins with the date of election rather than with the date of the qualifying event.

Although the regulations permit a plan to charge a premium going back to the date of the qualifying event if COBRA coverage is initially waived, few funds would elect to do this because a plan would always run the risk of picking up unknown, and potentially significant, medical expenses incurred between the date of the qualifying event and the date of election. It seems unlikely that most plans would want to run that risk. Therefore, when a qualified beneficiary is given a second chance to elect COBRA coverage which he has previously rejected, he is in the enviable position of dumping most or all of the same medical expenses on the plan as if he had not waived the COBRA coverage on an earlier date while escaping several months of retroactive premium which otherwise would have been charged.

The fact is that the COBRA rules are already stacked in favor of the qualified beneficiary and against the group health care plan as a result of the 60-day election period and the 45-day grace period for the retroactive premium. I realize that there is

nothing that the IRS can do about these time requirements because they are clearly set forth in the Act itself. However, since the 60-day election period and the 45-day grace period for payment of the retroactive premium are already guaranteed to accentuate the normal problems of adverse selection, the IRS should not stack the deck by giving a qualified beneficiary the right to reject COBRA coverage, save a couple of months of retroactive premiums and then pick it up again if he or she anticipates major medical expenses in the foreseeable future. Congress may have been supportive of adverse selection, but did Congress really want to extend it quite this far?

Not only would the proposed answer to Question 35 aggravate the adverse selection problem, it seems likely to add significantly to the administrative burdens already imposed by COBRA because funds would have to establish additional recordkeeping procedures to keep track of the revocation of waiver choices. Moreover, it appears that there is no limit on how many times a qualified beneficiary may change his or her mind during the 60-day election period so any fund's recordkeeping system has to be geared to accommodate numerous changes in the election and rejection choices.

Adding still further to the administrative burden would be the need to recalculate the retroactive premium and to notify the qualified beneficiary about the fact that his retroactive premium has changed due to the fact that coverage is only being provided back to the date of election and not back to the date of the qualifying event (unless the plan decides to permit coverage back to the date of the qualifying event which seems unlikely due to the increased risk of liability). The reason for this change in premium and change in coverage period will have to be explained by the plan administrator in a separate communication.

Consequently, if the answer to Question 35 remains unchanged, it may become a major factor in intensifying the problem of adverse selection far beyond what Congress intended and it will certainly add to administrative costs.

A preferred alternative (and one which has administrative simplicity as a major advantage) would be for the regulations to require that a qualified beneficiary make a one-time decision at any time during the 60-day election period to elect COBRA coverage and that absent a specific election, the plan administrator may assume that COBRA coverage was waived. This is simple to administer, simple to explain to employees and retirees, and fair to the qualified beneficiary.

Asking the qualified beneficiary to make a one-time decision concerning COBRA coverage would not alter in any way a qualified beneficiary's right to hold off making that decision until the last few days of the election period. Consequently, if a qualified beneficiary wishes to wait and see whether or not any major medical expenses have been incurred during the election period or are likely to be incurred in the near future, that option would still be provided as Congress originally intended.

Thus, the problem of adverse selection will remain but a one-time decision requirement would not increase benefit costs or administrative costs to the same extent as the proposed regulations would.

QUESTION 38: COVERAGE UNDER ANOTHER GROUP HEALTH CARE PLAN

The answer to Question 38 lists a number of events any one of which would permit a plan to discontinue COBRA coverage that is in effect. One of those events is: "The first date after the date of the election upon which a qualified beneficiary is covered under any other group health care plan that is not maintained by the employer, even if that other coverage is less valuable to the qualified beneficiary than COBRA continuation coverage." (emphasis added)

This statement makes it quite clear that if, at any time after the initial election is made, the plan administrator has reliable information that a qualified beneficiary has coverage under another group health care plan, then the COBRA coverage for that qualified beneficiary may be immediately cancelled.

This statement, however, gives rise to a question which is not specifically answered in the regulations, namely: "What if, at the time the election notice is returned, the plan administrator has reliable information that a qualified beneficiary who has elected COBRA coverage is already covered under another group health care plan --- would it then be permissible not to extend COBRA coverage in the first place rather than extend the coverage on one day and immediately cancel it on the next?

I assume that the answer to this question is "YES" but it would be helpful to all plan administrators if the regulations would spell out more specifically the right to reject any election of COBRA coverage if, at the time the election is made, the plan administrator knows that the qualified beneficiary already has coverage under another group health care plan.

The fact is that no plan wants to provide COBRA coverage if it doesn't have to so it makes sense for plans to establish procedures which will provide for the earliest possible detection of coverage under another group health care plan. One such procedure already being used by some plans is to request information from qualified beneficiaries at the time the election notice is mailed as to whether or not any member of the family is currently covered under another group health care plan. If the response indicates that some or all members of the family are covered under another group health care plan, then the COBRA coverage is not put into effect for such qualified beneficiaries even though it may have been elected because it could be immediately cancelled anyway.

I have talked with a number of plan administrators who are using this procedure and they have indicated that it has been quite helpful in the early detection of other group coverage. The early detection of other group coverage, in turn, keeps the plan from making benefit payments which should never have been made in the first place and relieves the plan from the legal costs of seeking the recovery of amounts paid by the plan which would not have been paid if the qualified beneficiary had properly reported coverage under another group health care plan to the plan administrator, as COBRA requires.

The point is that the early detection of duplicate coverage is extremely important if a plan is to exercise any control over the increased benefit costs and administrative costs generated by COBRA. For this reason, the IRS should do whatever it can by regulatory action to support a plan's early detection efforts. With this objective in mind, I'd like to suggest that the following wording be added to the answer to Question 38:

> A plan does not have to accept a qualified beneficiary's election of COBRA coverage if the plan administrator has reliable information that the qualified beneficiary is covered under another group health care plan at the time COBRA coverage is elected.
>
> It is permissible for a plan to request information directly from a qualified beneficiary at any time during the 60-day election period regarding whether or not the qualified beneficiary has coverage under another group health care plan.
>
> If the plan administrator requests information from a qualified beneficiary regarding his or her coverage under another group health care plan and the beneficiary fails to provide the requested information, then

the plan administrator has no obligation to offer COBRA coverage to the beneficiary.

This wording would not change a plan's obligation to send an election notice within 14 days after a qualifying event first becomes known to a plan administrator. It does, however, give the plan administrator an opportunity to discover coverage under another group health care plan as early as possible during the election period so that COBRA coverage is not inadvertently put into effect at the same time that it could be legitimately cancelled.

QUESTION 45: TIMING OF PREMIUM CHANGES

The answer to Question 45 is a welcome clarification of what time period must be used to determine the applicable COBRA premium. It is good news that the IRS has rejected an earlier interpretation of COBRA which would have required a plan to fix the applicable premium for 12 months beginning with the date on which COBRA coverage began for a specific qualified beneficiary.

This earlier interpretation would have prevented a plan from making any change in a qualified beneficiary's premium for at least 12 months after the first month's premium was assessed even though the plan may have experienced significant increases in benefit costs for similarly situated beneficiaries well before the end of that 12-month period. The only way a plan could try to keep up with benefit cost increases would have been to recalculate the COBRA premium every month for each new group of qualified beneficiaries who became eligible for COBRA coverage during any given month and that procedure would have been administratively burdensome and costly.

It is encouraging to see that the proposed regulations permit a plan to adjust the COBRA premium once during any given 12-month determination period and leave the definition of that determination period up to the plan sponsor. The only restriction appears to be that the 12-month period must be fixed in advance and "must be consistently applied from year to year." As a result, the premium for a particular qualified beneficiary may be changed in less than 12 months during the first year of COBRA coverage but would remain fixed for every 12 months thereafter.

The trustees of most multiemployer health care plans will probably select the plan year as the 12-month determination period since claims data and other cost data needed to determine the applicable COBRA premium is usually compiled on a plan year basis.

Nevertheless, there is a potential problem if the COBRA premium must remain fixed for the entire plan year since benefit improvements are often made during the plan year and a plan may experience an immediate increase in benefit costs due to the benefit improvements. However, as the proposed regulations are presently worded, it appears that the cost of such benefit improvements may not be immediately reflected in the COBRA premium because the premium may not be changed until the beginning of the next plan year.

This restriction could have adverse financial consequences for multiemployer health care plans because benefit improvements are often made during the plan year rather than at the beginning of a plan year. For example, if the benefits are insured, the 12-month policy period does not always run concurrently with the plan year and benefit improvements are usually made at the beginning of the new policy period (and not at the beginning of a new plan year).

Moreover, in the case of many multiemployer plans, the expiration date of the collective bargaining agreement does not coincide with the plan year. Consequently, when benefit improvements are agreed to as a result of collective bargaining, such improvements are usually put into effect shortly after signing of the collective bargaining agreement rather than waiting until the beginning of the next plan year. This means that any increased costs for the benefit improvements cannot be postponed until the beginning of the plan year but are incurred shortly after the new bargaining agreement goes into effect.

Under the circumstances described above, it seems reasonable to increase the COBRA premium during the plan year if benefit improvements have been made and if those improvements have resulted in increased benefit costs for similarly situated beneficiaries. In fact, permitting such an increase would be perfectly consistent with the congressional intent of allowing group health care plans to charge a COBRA premium commensurate with the actual cost of providing comparable benefits to similarly situated beneficiaries.

It should also be noted here that plans have no choice but to extend benefit improvements to COBRA beneficiaries as a result of a technical amendment to COBRA which requires that: "... if coverage is modified under the plan for similarly situated beneficiaries, such coverage shall be modified in the same manner for all qualified beneficiaries covered under the plan."

This puts plans between a rock and a hard place! On the one hand, plans must simultaneously extend benefit improvements made for active employees and retirees to their COBRA coverage counterparts while at the same time, the proposed regulations prohibit plans from recovering the actual costs of these improvements

from qualified beneficiaries until the next 12-month determination period.

This seems grossly unfair because, in effect, it forces plans to provide free coverage to COBRA beneficiaries for varying periods of time. I don't think that this is what Congress intended when it adopted COBRA's premium determination requirements, do you?

There really is no justification for imposing by regulation an arbitrary time lag between the time benefit improvements are made to qualified beneficiaries and the time at which the increased cost of such improvements are recovered through the COBRA premium. No insurance company will delay increasing its premium charge to the plan when benefit improvements are made so why should the plan have to postpone its premium charge to the qualified beneficiary for the same benefit improvements?

Not only does this arbitrary time lag work against the best interests of a group health care plan, but it may also work against the best interests of qualified beneficiaries in the event that benefits are reduced rather than improved. Under the proposed regulations, it would appear that if there was a reduction in benefits and that reduction resulted in a decrease in benefit costs, those cost savings could not be passed along to qualified beneficiaries until the beginning of the next 12-month determination period instead of at the time the cost savings are actually experienced.

Incidentally, a reduction in benefits is not an unusual occurrence these days as group health care plans continue their struggle to meet rising medical costs. As a matter of fact, I am familiar with several client funds which have recently found it necessary to reduce benefits on two different occasions during the same plan year. In one case, both dental and vision care benefits were eliminated. If the proposed regulations had been in effect and if a COBRA beneficiary had elected dental and vision care coverage, no reduction in the premium for that coverage would be permitted until the beginning of the next plan year despite the fact that dental care and vision care coverage had been eliminated. Clearly this seems unfair to the COBRA beneficiary unless benefit costs for similarly situated beneficiaries remained relatively unchanged despite the reduction in benefits.

Plan sponsors should have some flexibility to make COBRA premium adjustments within the 12-month determination period if it can be documented that there have been increases or decreases in benefit costs for similarly situated beneficiaries due to changes in the types or levels of benefits being provided.

With this objective in mind, I would like to recommend that the following wording be added to the answer to Question 45:

> In the event that the types or levels of benefits are changed at any time during the 12-month determination period selected by the plan sponsor and if, as a direct result of such a change, there is an increase or decrease in benefit costs, a plan may make an immediate adjustment in the COBRA premium to properly reflect that increase or decrease in benefit costs.

The wording proposed above is fair to the plan and fair to the COBRA beneficiary because it strikes an appropriate balance between the plan's need to recover increased costs as soon as possible after benefit improvements are made and the COBRA beneficiary's need to share in cost savings resulting from any reduction of benefits.

SOME CONCLUDING REMARKS

The preceding discussion has been rather lengthy and it seems appropriate at this point to sum up the major recommendations made in this letter for changes in the proposed regulations. THESE RECOMMENDATIONS ARE:

1. Disallowance of the tax deductibility of an employer's contributions for non-compliance with the COBRA requirements should be limited to the contributions made to any particular plan which is not in compliance and should not extend to all contributions made by the same employer to other health care plans in which he participates.

   This more limited sanction is still sufficiently harsh to discourage non-compliance by any employer.

   The regulations should also indicate that this more limited tax disallowance sanction will not be applied if any plan can demonstrate that: (a) it has made a "good faith effort" at compliance; (b) the violation was unintentional; and (c) appropriate corrective action has been taken to remedy the violation.

2. Example 3 in the answer to Question 17 should be modified to make it clear that if an unmarried child is entitled to and elects COBRA coverage and if he or she subsequently marries and has children, the new spouse or new children are not entitled to COBRA coverage unless the plan rules would have

extended plan coverage to the spouse or children of a dependent child, either automatically or as the result of an open enrollment period.

Also, an example should be added under Question 17 to make it clear that if a divorcee remarries, the new spouse or any new children or step-children of the divorcee would not be entitled to COBRA coverage unless the existing plan rules extend coverage to the new spouse, new children, or step-children of a divorcee.

3. The regulations should limit the election or rejection of COBRA coverage to one point in time during the 60-day election period in order to place some restraint on adverse selection.

The proposed answer to Question 35 which permits a qualified beneficiary to change his mind about electing COBRA coverage as many times as he wants to during the 60-day election period is an open invitation to adverse selection and will add to the administrative costs of COBRA compliance.

The problem of adverse selection will be bad enough under other COBRA requirements without the IRS regulations providing this further incentive.

4. Wording should be added to the answer to Question 38 to indicate that plans are permitted to reject the election of COBRA coverage by any qualified beneficiary if the plan administrator has reliable information that the qualified beneficiary is covered under another group health care plan at the time the election is made.

Wording should also be added to Question 38 which would authorize the plan administrator to request information about a qualified beneficiary's coverage under any other group health care plan when the election notice is mailed. The plan administrator should be given specific authorization to reject any election of COBRA coverage if such information is not provided within the 60-day election period.

5. Plans should be permitted to change COBRA premiums within the 12-month determination period IF the plan experiences benefit cost increases or decreases which are directly attributable to benefit improvements or benefit reductions.

It should not be necessary to wait until the beginning of a new determination period in order to cover the plan's cost

of benefit improvements or to pass along cost savings to qualified beneficiaries resulting from benefit reductions.

Adoption of these recommendations should facilitate the administration of many of COBRA's requirements while at the same time, assuring that the social goals of COBRA are achieved.

Sincerely yours,

David T. Livingston, Ph.D.
Vice President and Director
of Research

DTL:nv

540 Depot Street, Hancock, Michigan 49930 Phone: 482-7382

Western Upper Peninsula District Health Department

BRANCH OFFICES 210 East Mary St, Bessemer, Michigan 49911, Phone 667-0263
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725 Greenland Road, Ontonagon, Michigan 49953, Phone 884-4485 884-2047

August 18, 1987

The Honorable Donald W. Riegle, Jr.
United States Senate
Washington, D.C. 20510

Dear Senator Riegle:

I thank you for the opportunity to present information to you on health care issues, specifically focusing on long term care needs in the Upper Peninsula.

My name is Doctor Kenneth F[illegible]. I am the health officer/medical director of the Dickinson-Iron and West[illegible] U.P. District health departments. In 1986 The Western U.P. District Health Department received a grant from the Michigan Department of Public Health to conduct a joint study of the long term care needs of the Upper Peninsula.

Working closely with the staff of the Division of Planning of the Bureau of Health Care Facilities, Michigan Department of Public Health, we conducted a three-part survey. The attempt was to determine the long term care needs, as well as to inventory the facilities and programs providing services of a long term care nature.

The Upper Peninsula Advisory Committee, composed of representation from hospitals, nursing homes, medical care facilities. social service and other agencies, as well as volunteer groups and church groups, conducted an inventory of all of the facilities, agencies, and programs involved in long term care in the U.P.

The Michigan Department of Public Health contracted with University of Michigan, Flint, to do a telephone survey to determine the long term care needs of a random sample of Upper Peninsula residents.

A group of specially trained nurses visited patients in hospitals, nursing homes, care facilities, homes for the aged, and on home health care roles of the various randomly selected agencies and facilities. The purpose was to determine the long term care needs of those patients who are already receiving care.

The information from the telephone survey and the on-site survey by the nurses is still being reviewed by the Michigan Department of Public Health before presentation to the Michigan Legislature. Its findings and conclusions are therefore not available at

this time, but are anticipated to be presented to the legislature in September. I would suggest that it would be very helpful for your committee to obtain a copy of this report from Doctor Gloria Smith, Director of the Michigan Department of Public Health, when it becomes available later this year.

I am able to share with you some information which was obtained by the advisory committee in our survey of long term care providers in the Upper Peninsula. One of the striking features was that 14.5% of the U.P. population is over 65, compared to 10.7% of the entire state population. It also was turned up that access to health care was a problem, not because of the lack of professionals, but because of the distances people need to travel, and some of the problems with the transportation system. I would like to share with you some specific information regarding the apparent needs and the services being provided to people needing long term care in the U.P.

There are 34 nursing facilities which have 2,579 beds for long term care. This does not include the 103 nursing beds at the Jacobetti Facility in Marquette, although the Jacobetti beds are available to U.P. residents as well as statewide residents. It is interesting to note that there are more hospital long term care units and more county medical care facilities in the Upper Peninsula than in the state, on an average. In the nursing homes the average occupancy was 99%, with 10 homes being at 100%. Every home had a waiting list containing from 1 to 63 patients. The duplicated waiting lists contained 765 people at the time of the survey. It is difficult to estimate how many people this constitutes waiting for placement, because many people had their name on two or more long term care facility waiting lists.

In addition there are 10 homes for the aged in the Upper Peninsula which have 450 beds; the average occupancy of these facilities is 93%. In Michigan the Department of Social Services licences adult foster care beds, of which there are 220 homes in the Upper Peninsula containing 1,380 beds. To help round out the long term care from the official licensed agencies there are 11 home health agencies in the Upper Peninsula, some being private and some being operated by health departments.

It is obvious from the report from the advisory committee, which is available for scrutiny, that there appears to be a need for increase in long term care beds. If the numbers are used based on the information obtained by the advisory committee it would appear that up to 300 more long term care beds might be needed in the Upper Peninsula.

At this time it is difficult to give you an exact figure of the need because of the changing patterns of hospitalization utilization and people in long term care units. It is safe to say, however, that as of today there are still hospitals who are placing people

as far as 300 miles away from their homes to be in long term care beds, and people are still on waiting lists for placement in long term care facilities. It is a reasonable observation to make that the study done in the Upper Peninsula is one which might be useful for the entire state of Michigan, in fact the nation as a whole, as our population ages. Because we have a high proportion of elderly who need care we have a situation in which the government, communities, volunteer agencies and others need to work together to provide for a wide range of long term care, whether it be in a hospital unit, a care facility, a nursing home or some other facility. With the onset of D.R.G.'s two years ago, hospitals are not able to keep patients long and the need for increased beds to allow a smooth transition for a patient from an acute care facility to a long term care facility has become more apparent.

I thank you for the opportunity to present this information to you and would hope that you might find it useful to make use of the entire study once the information has been presented to the state legislature by the state health director, Dr. Gloria Smith.

Sincerely,

Kenneth E. Rowe

Kenneth E. Rowe, M.D., M.P.H.
Health Officer/Medical Director

KER:lb

Copy: Ms. Pamela Shaheen

1636 So. 16th Street
Escanaba, MI 49829

September 1, 1987

Senator Donald W. Riegle, Jr.
United States Senate
Washington, D. C. 20510

Dear Senator Riegle:

Last Friday, August 28, I was privileged to attend the hearing concerning catastrophic and long-term health care. Although I wished to express my views at the meeting, time and other commitments did not permit me to remain to the end of the hearing.

For your information I am a retired federal employee who gave 36 years of conscientious service to the federal government, including 26 years with the Social Security Administration, 19 years in a supervisory and managerial capacity. Since retirement and for the last few years, I have served as a volunteer medicare and health insurance consultant for the elderly.

Although I am basically in favor of a catastrophic health plan under medicare, I must protest the proposed method for financing the program. In addition to a substantial increase from $17.50 per month to at least $31.50 per month in the Part B premium by 1992, the proposal will also call for a supplemental income-related premium which would amount to $580 for each my wife and myself in 1988 and a gradual yearly increase to $1017 each by 1992. This means our cost for catastrophic health insurance under medicare would be over $3,000 per year for my wife and myself by 1992.

I believe the proposal is grossly unfair and inequitable and actually downright discriminating to us as federal retirees. This, despite the fact that we now have catastrophic insurance of our own with medicare and supplemental insurance.

As you are aware, the federal employees' pension benefits are fully taxable and our pensions plus years of careful saving and investment results in substantial yearly income tax. And, I assure you, Senator, that our income is far below the $100,000 a year income you cited in the meeting last Friday.

During the past several years, we have experienced a considerable erosion of our pension rights.

1. We have been denied a number of cost of living increases, that should have been paid under government policy.
2. I do not get Social Security benefits, but my wife receives a minimum benefit. In the past several years, one half of that minimum payment has to be counted as gross income for income tax purposes.
3. Health insurance costs have increased substantially, but with a healthy increase in deductibles and co-insurance.

I am a concerned citizen who believes it is important that the Federal Government can not continue to operate on tremendous unbalanced budget and understand that to ever achieve a balanced budget, people will need to tighten belts. However, the demands on federal pensions have been unjustly disportionate.

It is hoped that these concerns will be given fair and just consideration in the proposals for catastrophic health insurance under medicare.

Sincerely,

Arnold T. Williams

ARNOLD T. WILLIAMS
1636 So. 16th Street
Escanaba, Mi 49829

RESOLUTION

WHEREAS, the Marquette County Board of Commissioners realizes that many citizens in Marquette County, in the State of Michigan and throughout the United States do not have adequate resources to provide themselves with sufficient health care coverage to protect them in the event that a catastrophic or long-term illness would occur; and

WHEREAS, Marquette County has displayed its support for improved insurance coverage for those unable to obtain such insurance on their own, as demonstrated by our recent award of the State of Michigan Health Care Access pilot program grant.

NOW THEREFORE BE IT RESOLVED that the Marquette County Board of Commissioners urges Congress to consider passage of appropriate legislation that would protect the uninsured and under-insured in the event of long-term or catastrophic illness.

Adopted this eighteenth day of August, 1987

Timothy J. Love

Timothy J. Love, Chairperson
Marquette County Board of Commissioners

I David J. Roberts, Clerk of the County of Marquette, State of Michigan, do hereby certify that the foregoing resolution was adopted by the Marquette County Board of Commissioners at their regular meeting of August 18, 1987

Sworn to by me on this 25th day of August, 1987

David J. Roberts

David J. Roberts
Marquette County Clerk

CATASTROPHIC AND LONG-TERM HEALTH CARE

WEDNESDAY, NOVEMBER 11, 1987

U.S. SENATE,
COMMITTEE ON THE BUDGET,
Detroit, MI.

The committee met, pursuant to notice, at 1:15 p.m., at Martin Luther King Junior-Senior High School, 3200 E. Lafayette Street, Detroit, MI., Hon. Donald W. Riegle, Jr., presiding.

Present: Senator Riegle.

Staff present: Joan Huffer, legislative assistant; and David Krawitz, legislative director.

Senator RIEGLE. I want to welcome all of you here today and thank you for coming.

I think we should all be thankful that we can gather here in this magnificent auditorium that we find ourselves in today. I want to thank the school for allowing us the chance to be here and use this very fine facility.

I wanted to also at the outset—because this is Veterans' Day—I wanted to ask all of you to join with me in pausing for a moment to acknowledge our veterans both living and deceased who have given so much to our country. I know we have many veterans in the audience today. We appreciate that service and the services of all men and women who have served our country and worn the uniform of our country in the past and in the present.

So let us, for a moment, particularly remember those who lost their lives in service to our country.

[Silence.]

Senator RIEGLE. Thank you.

OPENING STATEMENT OF SENATOR RIEGLE

Senator RIEGLE. Now, today we are having an official hearing of the Senate Budget Committee on the subject of health care needs of our senior citizens particularly and of uninsured persons of all ages.

We have held other hearings across the State of Michigan, but this hearing today in the City of Detroit is the culminating event. It is being held now because we are completing the work on a major piece of catastrophic health care legislation in the Congress which I will describe to you in just a moment.

We have some very important witnesses here today who are going to help us all understand better and to help the United States Senate understand better exactly what the health care needs are in this community.

And so we have some individuals who are seated down here who we will meet and hear from in due course. They've been kind enough to agree to come and tell their personal stories.

And then we have some professionals in the health care field who will give us a perspective from their vantage point to help fill out the picture.

After they have had a chance to speak, we are then going to invite anyone in the audience who wishes to speak and tell their own personal story or to make a point about health care, or make recommendations to do so.

We have asked that anybody who wishes to speak to let us know so we can put the names in order. And then as we go down through the afternoon, we're going to call on people to go to these microphones that you see down in the hallway areas to speak.

Any of you that wish to express some ideas or thoughts but don't want to get up and speak, I'd like to have you then put it in writing. We have paper and pencils and pens, and anyone who wants to give some testimony in that form is encouraged to do so.

Now, we're here to talk about several different, specific health care issues. We're here to talk about catastrophic health care for senior citizens. For example, major illness can bring large doctor bills that can overwhelm people in terms of their health and their finances, especially when insurance coverage is united. So we're going to address that.

We're going to address the issue of health care for people that have little or no insurance. And that is a very large number.

We are also going to hear some discussion today about infant mortality, because infant mortality here in Detroit is a major problem. We have the highest rate of infants not surviving of any city of our size in the United States.

And in fact, statistics are so bad at the present time that a child born in this city now has less chance of surviving their first year of life than babies that are born in Chile or Costa Rica or Jamaica or a host of other countries around the world that you would tend to think would not have medical care as good as ours.

So we'll be touching on all of those subjects.

Let me move immediately to the issue of senior citizens.

Despite the fact that in this country last year we spent $74 billion on Medicare, we're finding that many seniors are still being driven into poverty by huge medical bills.

And we all know stories—some personally—of how a single illness has come along. And no matter how hard you've worked all your life, no matter how hard you've sacrificed and saved, your entire life savings can disappear virtually overnight for just one major illness.

That situation has got to be changed, and it can be changed. We're here today to talk about the problem and talk about how we can go about fixing that problem.

We have been working on legislation in the Senate to add new catastrophic health protection to Medicare.

Many of you that are senior citizens in the audience today have subscribed to insurance plans called Medigap Plans to try to provide some protection for yourselves beyond what Medicare through the government now provides.

And let me just ask, if I can, for a show of hands. How many seniors here in the audience today have some kind of private Medigap insurance in addition to their Medicare coverage under social security? Would you raise your hands?

[Show of hands.]

Senator RIEGLE. So we have a very substantial number here who presently are paying for that extra insurance coverage. And we'll get into that in a short period of time.

Now, President Reagan earlier in the year, to his credit, came forward and said that it was time to expand Medicare to provide coverage for catastrophic illnesses where seniors run up huge medical bills that are not presently covered by Medicare.

He also said that he thought Medicare should be expanded to cover those kinds of major acute illnesses, but that any increase in the coverage would have to be paid for. The government wouldn't pay any of it; it would have to be financed through an insurance system by all of us who participate in the system.

So we have set out in the Congress within those guidelines to produce a catastrophic health insurance protection to add on Medicare, and we have now done that. We have passed the bill in the Senate, and the House of Representatives has passed a bill. We are now in a conference committee to join those two bills into a single bill and then send it on to the president for his signature.

All of the signs are that we have worked out a compromise that is the best we can do at this particular point and which the president will sign.

And so we are about to make an expansion in the health care coverage under Medicare, and this is how it will work. Bear in mind that it relates to the major illnesses that usually send somebody to the hospital and generate substantial hospital and doctor bills.

The new expansion will limit to the amount of money that those bills could cost senior citizens on Medicare. That limit would be a maximum of $1,850 a year. Now, that's not an insignificant amount of money. But I could tell you of case after case where seniors have gone into the hospital for major heart surgery or other major kinds of help, and the bills have been $40,000, $50,000, $60,000, $70,000.

Now, any amount up in that high range above $1,850 a year would be covered by this new insurance protection. That includes both the hospital bills and the doctor bills together. So it would cap off the amount that those serious illnesses could end up costing you directly.

This extension in Medicare also increases coverage for skilled nursing facility care from 100 days to 150 days. There is also some broadening of coverage for home health care and hospice care.

Now, the president had nothing in his proposal on prescription drugs or medicines. Some people here today have already asked me about that. Some of you had said that one of the most serious problems is trying to pay the costs of prescription drugs because very often if we've got the right medicine, we can stay out of the hospital or we can ward that off for a long period of time.

We added an amendment to the bill that we passed in the Senate that will provide some additional coverage for prescription drugs. I will describe that in a minute.

We also adopted an amendment that would prevent a husband or wife from losing everything when one of the two has to go into a nursing home for long-term care. As it is now, if a married couple is in a situation where one has to go into a nursing home, the partner who stays at home can become impoverished. A nursing home costs on the average about $22,000 a year. It could cost certainly more than that.

But the way it is now, once you have one of the two in a nursing home, you usually have to spend your own resources because few insurance policies pay for this kind of care. You have to, in a sense, get rid of everything you have in order to qualify under our welfare system for Medicaid in order to keep paying those bills.

In many cases, this can destroy in many ways the life of the person who remains at home.

In fact, a lot of people have been advised by lawyers to get divorced as a way to protect the assets so that the one person could still qualify for assistance nursing home care while the other person could live at home.

That is a horrible situation, and it doesn't have to be that way. We have put an amendment in the bill to deal with that.

Now, the way we would pay for this is the basic Medicare premium of $17.90 a month, that automatically gets deducted from your social security, would go up $4 a month. That's what it would cost to get this additional protection. And that's something that everybody would pay.

In addition to that, there would be a sliding scale premium that people of higher income would pay. It could range up to as much as $0 to $800 a year. But 60 percent of all the people in the country—and I suspect almost everyone in this room—would not pay the supplemental premium because that only would apply to people who have very high incomes.

With this new coverage, many of you that now retain the private Medigap insurance, would be able to discontinue that extra insurance. Since you would no longer have to pay for that, you would be able to save whatever that now cost you.

So, you will have this new protection for catastrophic illnesses coming under Medicare, for which $4 a month would be deducted automatically from your social security payment.

Now, there are some limitations to it, and we should understand those.

I'm going to try to hurry here. I don't want to go too fast because these things are complicated, and you need to know what's in this package. I want to have you react to it as the day goes on.

These proposals deal only with acute illnesses or extreme medical problems which now would generally send somebody to the hospital. It does not cover routine medical exams, dental care, or eyeglasses and does not cover chronic, long-term health problems that require home health care or nursing home care—things like alzheimers, stroke, MS, lupus, or arthritis.

But we have more and more older people in our society who are afflicted with those problems and who need ongoing, expensive health care. And today there is little or no coverage for that.

And the plan that we developed, while it covers acute hospital illnesses, it does not go further and cover these other items. So that is still a problem area for which as yet we don't have an answer.

Long-term health care is costing us as a society right now about $37 billion a year. That's a lot of money. I mentioned that the average cost per year for nursing homes is about $22,000. If somebody has to go into a nursing home and pay for that out of their own pocket, it can draw down their savings very rapidly. And Medicare does not pay those bills as it's now constructed.

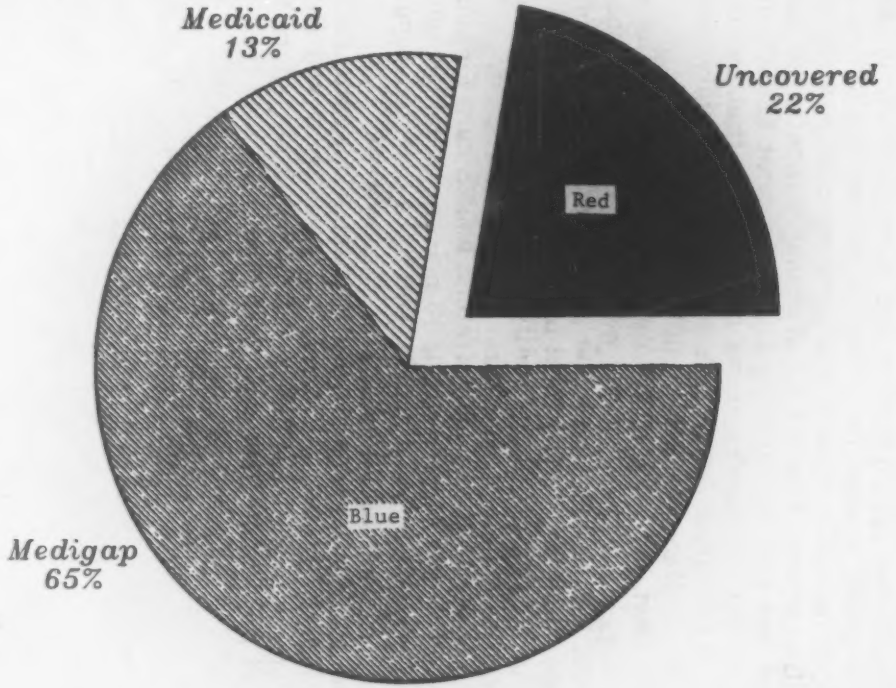
When that happens, it not only impacts the senior citizen and his spouse, but it goes all the way down the family chain, because it affects the children and the grandchildren and everybody else. So these should not be thought of as just problems that hit one age group in our society. They really stretch across our whole society.

Now, I want to show you three or four charts.

This chart shows how catastrophic health care for senior citizens is paid for today. It shows that 13 percent of catastrophic costs are covered by Medicaid. Of course, you have to exhaust your assets to qualify for Medicaid under our welfare system.

About 65 percent of our senior citizens today are covered by private Medigap insurance plans which many of you indicated you have. The area in red shows that 22 percent of seniors have no coverage at all beyond Medicare, principally because they can't afford it.

CATASTROPHIC HEALTH CARE COVERAGE FOR SENIOR CITIZENS



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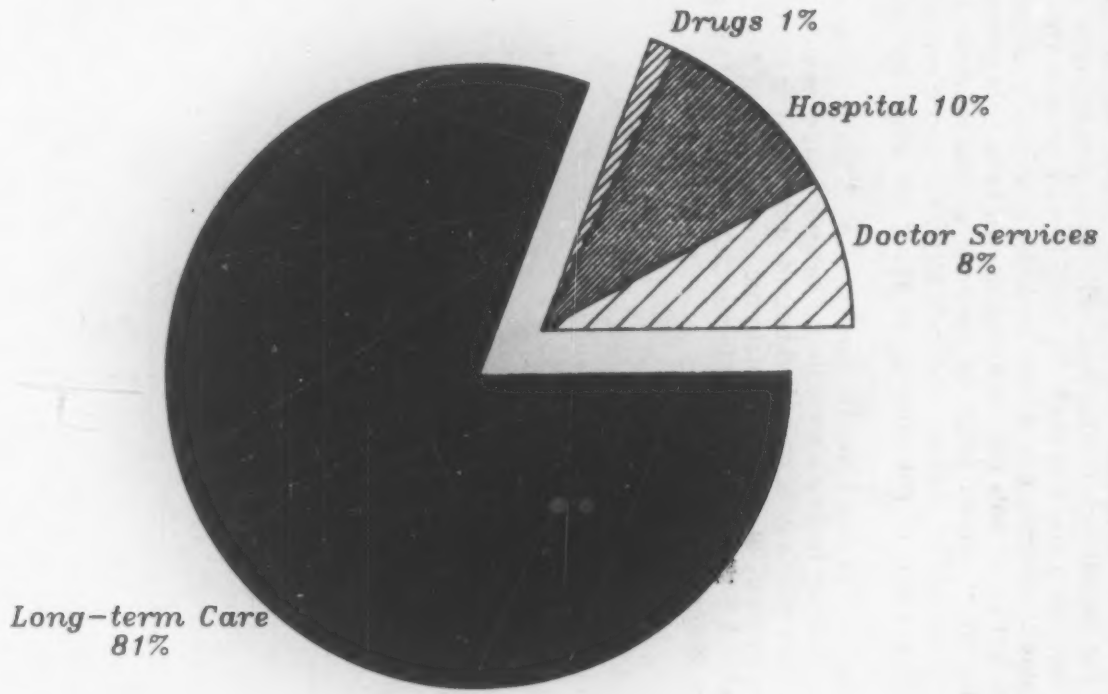
And so our proposal that I just described which expands Medicare for catastrophic illnesses, will now protect this whole group that has been unprotected. In fact, it will protect this group with Medigap insurance too, which includes many of you and will mean, as I say, that it will not be necessary to keep this private coverage.

This chart shows what is generating catastrophic expenses for older people. For seniors who pay $2,000 or more out of their pockets, 81 percent of that money is going for what we call long-term care.

Now, this is not time in the hospital. This is time in a nursing home or time in one's own home getting home health care. This is somebody who's generally bed-bound and requires basic care.

Ten percent of these catastrophic costs is going for hospital bills and about 8 percent is going for doctors' services. One percent goes for medicines.

CATASTROPHIC OUT-OF-POCKET EXPENSES OF THE ELDERLY



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Now, this new expansion of Medicare into catastrophic health insurance that we are about to enact basically deals with the problem of hospital, doctor and drug cost. It does not deal with the problem of long term care.

This is one of the issues that we have to confront now as a nation. We now have a presidential election coming up, and you've got a lot of candidates that are running. You need to know where they stand on these issues, and to make sure they address them.

We need to ask ourselves how we feel about this problem? Is something needed to address long term care? Does the government have a role to play? If so, what should it be? How do we get it done? Do we just look the other way with respect to people who are in these circumstances when this is the lion's share of major health care expenses for elderly people in this country?

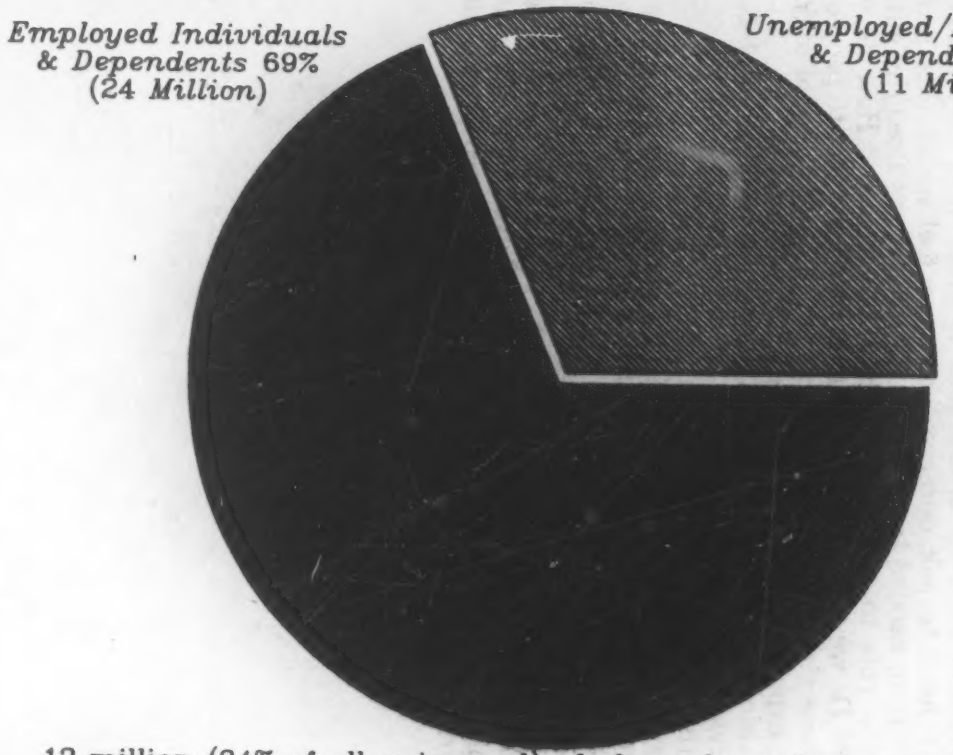
I think the answer is no—this is a real problem, and we need to address it.

I think we'll hear things about that today.

I want to now shift over and talk about younger people who are uninsured today, many of whom are out of work.

This chart shows that of all of the people, who have no health insurance as depicted by this graph, fully 69 percent are working. This is a surprise statistic, I think, to a lot of people because we tend to assume that people who don't have insurance must be unemployed. That's partly true—most unemployed people don't have insurance.

EMPLOYMENT STATUS OF UNINSURED INDIVIDUALS



12 million (34% of all uninsured) of above dependents are children.

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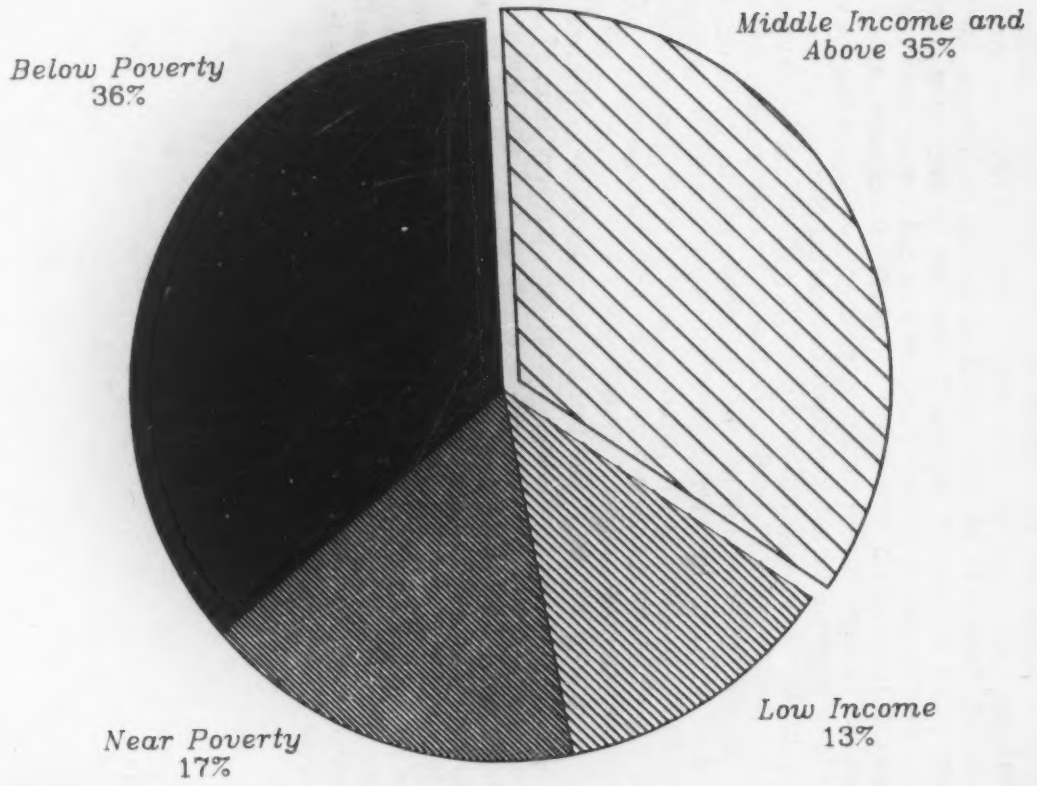
But it turns out that there are an awful lot of people who are working, but who do not receive health benefits and are not making enough to be able to afford health insurance. By the time they pay the costs of getting themselves to and from work and to feed themselves and their families and put a roof over their heads, there is little or no money left for health insurance. And health insurance is expensive; particularly when you try to buy it independently of a group or work-related incurance plan.

I think it is also significant that 12 million—or 34 percent—of all of the people without health insurance in this country are children. When we think about the health needs of our children, the idea that 12 million children in our country have not a shred of health insurance protecting them today, I think it is a disgraceful statistic. It's something that we also need to understand, I think, and be prepared to do something about.

If you take a look at the family income of the uninsured, we find that 36 percent of the total is below the poverty line, 17 percent is near poverty, and 13 percent is what we call the low income. So people with very little money to get by on are a very large part of this group of the uninsured.

But significantly, a full 35 percent are people who are not in the low income category. They actually are in the middle income category. That description is deceptive because those people still do not have enough income, after they meet the other necessities, to be able to afford health insurance.

Family Income of the Uninsured
(Under 65 Years of Age)



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So those were the two problems that I wanted to bring here into discussion at the outset. We'll talk more about them as the day goes on. But these are two major items that we wanted to address at the outset.

I'm going to start with our first panel of witnesses. Before I do, I want to acknowledge four individuals in the audience. I don't know where they're seated. But we have County Commissioner Bernard Kilpatrick here. We're pleased to have you with us today.

We have County Commissioner Jackie Currie, Winston Lang from the NAACP, Morris Goode, Sr. is here, and others, I'm sure, that I have not had brought to my attention.

Now, let me start down through our list of individual witnesses. And I want to thank them for coming today to testify, as others of you will in the audience later.

Our first group of witnesses are individuals who have encountered catastrophic health problems first-hand in their own lives, and they're going to tell us about them today. They are going to tell us about the kinds of problems that arise when health coverage is not available or when it's not sufficient to take care of health care expenses.

It is not easy to talk about these problems. It's very hard to talk about them, and it takes a lot of courage to do it in the open in a public meeting. And that's why I'm so grateful that these witnesses are prepared to do this and make their stories part of the official record of the Senate Budget Committee so that we know what the problem is and can begin to craft a meaningful solution.

Our first witness is Betty Jones. She's from Detroit. Ms. Jones is going to tell us about her battle with cancer and how it was complicated by her inability to get insurance or Medicaid assistance.

Betty, let us move the microphone down in front of you, and I think it will probably work quite well. If you can't hear her in the back of the room, please let us know so she can hold the mike a little closer.

Betty, why don't you go right ahead?

[Pause.]

Senator RIEGLE. I think you may have to hold it even closer. You may have to put it right up close to your mouth.

STATEMENT OF BETTY JONES, DETROIT, MI

Ms. JONES. I have been battling cancer for the last 8 years. I was working and my job gave me the opportunity to take my vacation, and I was on disability. After disability, I went to social services for help to go to chemotherapy three different times and radiation two different times.

Each time I went to social services, they wouldn't give me extra time 30 to 25 days that I had over there whether I had insurance or not. Even though I was supporting my son, they said I was getting too much, which was $12,000, the minimum that they would allow me to have, so therefore they would not order treatment. I couldn't get it because I didn't have the funds to pay for them or I would have to tell the social services the people that they have which they could tell me they would. I would get the services done.

So therefore I paid the hospital a certain amount of money and I paid the doctors a certain amount of money.

My next episode that I did was I called all the people that I thought could help me for the chemotherapy. I asked the worker if I would be covered. She said, yes, I would be. I didn't want to have the surgery so I decided for the chemotherapy. They were telling me that I was not eligible because of the "x" amount of dollars from Social Security.

Well, I couldn't pay the doctor out of the $600. So I refused that and I called the worker at Providence, and she in turn called social services, and they insured me again, but each time they would insure me for 3 months and they would cut me off because I was $12 over.

And I would go back and wait for 30 or 45 days to see if I was going to get it again. They would put me down for 3 months each time and then cut me off. That's something you have to cope with battling cancer. You can't stay above water when other people have got insurance.

So I have gone through this business for the last 5 years. Now, I think I'm going to look into if I can get Medicare, but I need Medicare now and then I don't have to worry about where it is going to come from.

Senator RIEGLE. Betty, let me ask you a couple of questions if I may. Can you give us an idea of how much your treatment has cost you so far in total, just rough numbers?

Ms. JONES. Right now, I probably owe the hospital over $3,000, and I owe the surgeon close to $1,000.

Senator RIEGLE. I see. Do you have any way of knowing how much your total cost has been since you were diagnosed as having cancer?

Ms. JONES. No, I don't, but in the first 3 years, I had insurance at my job where I worked. So up until only the last 5 years have I been aware of the prices and how much it was costing me.

Senator RIEGLE. And while you're trying to meet these bills that you have outstanding right now, what has this caused to happen just in your family? Are you able to meet the other necessities?

Ms. JONES. Barely.

Senator RIEGLE. Barely.

Ms. JONES. Yes, with the check I get from my health and my son. He's 16-years-old. He earns barely the minimum. Up until last month I got Medicare from social security so I don't have to pay for my medicine. It would also pay for my medicine, which one medicine I take costs $85 a pill. So that's a lot of money, and this will go on for a year, this chemotherapy.

Senator RIEGLE. One of the big gaps in coverage today which your case illustrates is you had to wait 2 years.

Ms. JONES. Yes, on social security.

Senator RIEGLE. You had to wait 2 years after you knew you had this problem, after you had been diagnosed, before you got the help.

Ms. JONES. Yes.

Senator RIEGLE. For the life of me I don't see how we justify when somebody has been diagnosed as having cancer and desperately needs the help, and may or may not be able to pay for it, to

say you just do the best you can for 2 years, and if you're alive 2 years down the road, we'll be there to help you.

Ms. JONES. Well, I decided, come hell or high water, however this was going to be paid—my child could take care of himself—I went to the hospital so that's how I accumulated the bills because the social services said they would pay but they did not pay. So I kept going anyway because I wanted to live. So I accumulated the extra bills.

Senator RIEGLE. Betty, thank you for coming and telling that story and sharing it with us. Thank you. [Applause.]

Our next citizen that we'll hear from is Tracy Smith who is also from Detroit. Mr. Smith has sickle cell anemia and is going to tell us how not having medical coverage to pay for his treatment has really forced him to have to do a whole lot of things that have been very difficult.

So Tracy, I appreciate your coming and sharing your story with us. Why don't you just go right ahead.

STATEMENT OF TRACY SMITH, DETROIT, MI

Mr. SMITH. Good afternoon, Senator Riegle. My name is Tracy Smith, and I was a student at Southwestern Christian College. I am 21 years of age. My problem is sickle cell anemia. OK. When I was younger that I didn't have a problem with Medicare because it would go on my mother's insurance, but now that I am not a minor they won't pay it. I was attending school and the problem is when I get ill, I can't pay for the bills because I don't have any insurance. So that stopped me from going to school. I had to come home. I can't get a job because no one wants to take the risk.

I don't have any insurance at all to cover me so I can't go back to school after this and put my mind on homework. I was going to school to be a minister and a lawyer, and it really hurts that I can't do things I'd like to do in my life, and it's stopping me.

So now I have a $3,000 bill that's growing rapidly, and I can't pay for it because I don't have the insurance, and when I go to some social security agency, I can't get the GA or disability because they say I'm over 18 and under 65.

So what they tell me is that I'm not eligible for it which is not my fault. I did not ask for this, but there's nothing really I can do. I'm just short of the mark. I work at odd jobs like rake leaves.

This morning I felt very defeated. I have other problems also without my medicine. I am over weight for a person of my size. I weigh 240 pounds and I'm very much blessed and thank God. It's hard.

I can't go back to school because there's no one to pay. I just can't do anything. There isn't too much more I can say.

Senator RIEGLE. Tracy, that's a very powerful story that you told us and it illustrates this problem where our country chooses to look away from problems like this. You say you fall into that gap in terms of your age where the system is not there to help, and you're in a situation where no matter how hard you try to help yourself you can't really do enough at this point because of the cost of treatment you need and the fact that people who might have jobs don't

want to hire you because of the fact that you've got medical problems, and they don't want to be saddled with that.

You, in a sense, almost disappear. It's like you become almost a nonperson in our system, and I'm going to put some questions to the audience a little bit later as to what you feel as a group we should do about this, because it seems to me that while Tracy is the person standing there right now, that could be any one of us.

It could be any one of us because that's just the way these things work. It could be anybody in our family. Are any of us going to deserve any help if we don't help him? I mean, it seems to me we have to help each other.

What happens to him really in the full sense is what happens to us. If we're not prepared to think in terms of ourselves or the society where we care about each other, I'm not sure we're really going to have much as a society.

Let me just ask right now for a show of hands. How many of you feel in this audience, and I'll ask both yes and no, that it's time for this Nation to establish a national health insurance program of some form that covers people of all ages. [Applause.]

Let's see the hands. Hold the hands up nice and high.

[A show of hands.]

Senator RIEGLE. All right. A very substantial, an overwhelming majority. How many have reservations about it and are not convinced with it? I see at least one hand. I see one up in the balcony. So there are a scattering of hands of people who take the other side, and that's America. Different people see problems different ways.

But it's clear that the overwhelming majority of the audience feels that we need to extend our health insurance system so that we pick up everybody in society which would include the young man who is standing before you right now.

Tracy, thank you for telling your story. [Applause.]

Let me now introduce Gloria Wise. Gloria also comes from Detroit. Ms. Wise's mother recently died after a long illness, and she is going to tell us about the catastrophic medical bills that can be associated with a long-term illness of this kind.

Gloria, we welcome you and we appreciate hearing your story.

STATEMENT OF GLORIA WISE, DETROIT, MI

Ms. WISE. Good afternoon everybody.

I'm here to just give you a little information about my mother and our experience that we had. My mother was a 76-year-old lady who had a stroke, a bilateral stroke. It affected both sides. She was unable to use either side. She was unable to take care of herself totally.

When you get this kind of patient in the society, there are many problems. There are problems with the institution taking care of her. There are people who don't understand and, in fact, who can't hear what the problems are.

One of the things we needed for my mother because she also could not speak, but she could tell you by speaking with her eyes, was that we hired someone with the help my sisters. Paid about $400 a month for someone to come to be with her at least 5 to 6

hours a day so that she would know if she needed something she could try to communicate with that person.

I'd also like to say that in the time that she was in the hospital, for 5 months of that time, there was a bill of $270,000. That does not include the bed. She's under very special care because she could get bed sores which should not happen. She had bed sores and other things with them.

Her system would be poisoned because sometimes people are not turned enough, and too much pressure is put on a particular area of the body.

Many other things such as the bed like I said before was not in that cost. The feedings, more than two feedings, that was not part of that cost. I'm talking about 5 months. My mother was dead in 10 months.

So you can see in that length of time it cost about a half of a million dollars. Nobody can save that. I don't care if you are making good money. The average person could not put aside enough money to even start to cover their needs when they get sick with a catastrophic illness.

With the help of the family—there are so many different costs. When you go there every day, just the cost of parking in the parking lot and the insurance and the needs costs like $1.50 a day for every day of the week. That's $45 a month. If you share everything together, it is very costly.

Now, my mother did have another insurance when she retired which my father received after retirement, but I must say even with Medicare and the insurance company, it did not cover all the bills. I still do not know what our portion of the bills will be. The hospital in Detroit still has to get together with the insurance company to see what our costs are going to be.

Now, my father is blind. My father has a very minimum income. He does have one additional problem. We found when he was getting ready to apply for Medicaid so that my mother could go back to the nursing home because she was between the hospital and the nursing home.

And if you know about the DRGs and understand about the DRGs, you understand what I'm talking about. When my mother went to the nursing home, she stayed there 2 days and she would get ill and they would send her right back to the hospital. The hospital would keep her for a short time and send her back to the nursing home.

She was like a ball between two bats going back and forth, but it is very, very costly also.

Another thing I think people need to know is if you are not skilled care, Medicare does not take care of your nursing home. You have to present that you need a nurse, a nurse for therapy or have a catheter or something that a nurse has to take care of. Otherwise it's considered custodial care, just maintaining you. If you do not have that, that cost is passed on to the family.

We were in the process of applying for Medicaid, but before we could apply for it, my mother had a piece of income property. We were told we could sell that property so that we could use the money to pay for nursing home care. My father now has to maintain also.

So with her check from Medicare going for the nursing home, the Medicare check, my father has much difficulty trying to make ends meet. Like paying those gas bills, the taxes and other things that you have to pay for the other spouse to maintain.

That seems to be not to be thought of too much because the other spouse suffers quite a bit, and the reason why I know this is because I take care of my father and we add so that my father can survive.

I guess there is not much more to say. It's just that it's really been an experience. I work in a county hospital. I've seen these problems.

One of the biggest things in my whole life was when I became a public health nurse. I go in and I see people who don't have money to even buy the necessities they need. They don't have the money to buy the food. If they're on a special diet or even a diabetic or whatever, they don't have the money to do what they need.

One thing you need to look at, too, and I'd like to say this. We need to look at preventative health. We're talking about all the problems that come down. We need to establish this with our young people in school—[applause]—and keep them in and protect good health, because the cost of good health, the cost of medical care is too much. We've got to do it better.

Senator RIEGLE. Gloria, thank you very much.

You mentioned that the bills in this case were approaching probably a half a million dollars when everything is totalled up over the 10-month period of time. That is just the dollar cost. As horrible as that is, the emotional wear and tear, the heart ache, the fact the family is going through terrible trauma of someone whose life is slipping away, being shuttled back and forth, as you say, between a hospital and nursing home with the cost going through the roof, is also very difficult. It seems to me that in many ways we've lost sight of what we should be looking at.

That is, what is the humane thing to do. What do we need. What is right. The notion that we can't afford it is a false notion. We're spending an awful lot of money today in our society—[applause]—and our Federal budget this year alone is a trillion dollars. We are going to spend a trillion dollars in 12 months on all the different things the Federal Government does.

We can't afford to waste money. We have the resources and are wealthy enough as a Nation to devise a system that meets these health needs, including the preventative part.

You're so right about saying, too, that we need to help people know what steps to take in the beginning in terms of preventative medicine, the right kinds of exercise and eating habits and everything else to prevent some of these things. We let people work their way into problems and a lot of times we don't even know what's happening until it is too late.

When you step up in front of us and tell that story you do it so well and so beautifully that I don't think anybody should fail to understand the emotional impact of what that story is when you're living through it hour by hour, day by day with someone that you love in that situation. We do understand that and we thank you for coming today and telling the story. [Applause.]

Our last panelist at this point is Betty Sullivan also from Detroit. Ms. Sullivan is going to talk about her husband's battle with Alzheimer's disease and how it affected her life.

Betty, we thank you for coming and I would ask you, too, to speak right into the microphone so everyone can hear you.

Betty Sullivan.

STATEMENT OF BETTY SULLIVAN, DETROIT, MI

Ms. SULLIVAN. Thank you, Senator Riegle, and members of your committee, and my brothers and sisters in the audience. I thank you very much for giving me this opportunity to appear before you today with my concerns for the catastrophic medical care plan.

I want to share with you my own experience, and on behalf of the millions of caretakers whose loved ones are stricken with Alzheimer's disease and other related illnesses. I'd like to point out, as Senator Riegle already has, that this proposed medical plan does not cover the long-term care for Alzheimer's disease and patients with related diseases. I can't think of a more catastrophic illness that affects the person as well as the people who care for him.

As most average Americans, working Americans like myself, I held the hope that my insurance coverage and my husband's Medicare coverage would take care of nursing home facilities that are ideal and they get paid for, right? You must think again. They are not.

On the other hand, with the health care, I have to pay part. The bill was around $2,200 or $2,500. This did not include the medicine, doctor's visits, other care or whatever. Just the basic care.

So to that amount of money a month, it's not very large, and the average person can't make it very well like the woman talked about the bills and health benefits. You're going to be OK, and save your money for vacations and retirement and what-have-you.

But when this illness hits, it doesn't seem right for it to go. It is estimated in the report by the Michigan Department of Public Health that Michigan will have 99,800 to 134,500 persons with Alzheimer's disease in the 65 age category by 1990. Now, you multiply that by the number of people that will be affected as caretakers and friends.

Although Alzheimer's disease can be acquired anywhere as a medical problem, Medicare and insurance does not consider it to cover. The victims cannot feed themselves, cloth themselves or other necessities. It is not covered by insurance for the long-term care.

I want to point out that Medicaid will cover fortunately, that is, if you're indigent or meet the following age requirements. If you have income, all of that income must be applied for care, except $27 for personal needs; and if there is a spouse remaining in the home, the spouse is allowed $270 a month to make it. This is an accepted standard regardless of what is presented to them. So you are forced to accepting welfare from your own State.

On the other hand, if you have never worked and don't have any income, Medicaid pays the full amount of your coverage. Not only that but they also give you $27 for your personal needs. It seems to me the Government puts a sanction on people who are working,

being productive and paying for medical insurance; and on the other hand, rewards somebody who has been, shall we say, unproductive.

Let me just explain what I mean. When I say unproductive, I don't mean somebody who can help being on it. As a social worker for 22 years with the department of social services and for 4 years as working as a nurse, say I have patient A in bed one and patient B in bed two.

Patient A has worked most of his life and has a small pension and social security, a life style that is simple, and he is able to walk around the nursing home. He is allowed $270 for his personal needs. If he wants to write a letter or get a haircut, buy a magazine, he doesn't have anything extra for cigarettes.

Patient B, on the other hand, has not worked or contribute. He has no pension, no Social Security coming in. The State pays all his medical coverage, and then they give him an allowance of $270 a month.

Now, I have a question on this. There seems to be a lot of innocent people who want to struggle and work and have something rather than being dependent on the State. My friends, we have to pray that we don't turn our backs on an illness such as Alzheimer's disease or any other related disease.

I thank you for the time. [Applause.]

Senator RIEGLE. Thank you so much for sharing this insight. You have lived with Alzheimer's so you know what it is and others have direct experience like you as well. At one of our other hearings, I had a gentleman come who was in his 70s, and his wife was suffering from Alzheimer's, and he was indicating they did not have the money for any outside care. He was giving all the care himself.

He was very tired the day he came to the hearing, and he wanted to have his story out on the record so we could know what was going on. He told the story of how he would lay right beside his wife at night because she had a habit of waking up in the middle of the night and would not know how to care for herself or who she was. He was frightened she would get up and hurt herself, and he wouldn't know it unless he was right there. He would wake up when she woke up.

As she was waking up at different times in the course of the night and he was caring for her at night and during the day, it was wearing his health down to a point where he said that day that he thought it was only a matter of time before his health was gone, and then he didn't know what was going to happen.

Ms. SULLIVAN. I understand that perfectly, Senator. One of the reasons why I took early retirement from my job was this Alzheimer's patient. I said 24 hours care but it's really 36 hours of care, and the care giver has to be there at all times. The person may wander away. They're preventing them from setting the house on fire. There is a whole number of things they may do.

The care giver is worn out too, and it is very, very difficult. I would hope here for support for the Alzheimer's support groups. I am running out of my money. I don't have money from my personal needs to give them to perform certain health care things.

Senator RIEGLE. Betty, thank you very much for coming and sharing your story. [Applause.]

We spend a great deal of money to deal with things that are going on in the world, such as this huge naval force in the Persian Gulf, which is very expensive and dangerous, and we spend a great deal to create a defense shield around the world which other allies, the Germans and Japanese and others count on us to do—we pay much of their defense. Now there is a proposal for a Star Wars system. The cost estimate is at least a trillion dollars.

Now, a trillion dollars is a thousand billion. I think one of the questions that we have to ask ourselves as a society, especially because we do have a presidential election coming up next year and there's a wide open contest going on in both parties, is where do we really want the emphasis put in the future, because the resources are out there.

If we want to see these resources devoted to meeting health care needs in a sensible system that provides the kind of coverage where every one that needs health care has an opportunity to get it when they need it and without being driven to the poor house in the process, we can have that kind of thing if that's what we want and if we're willing to work to get it.

My feeling is that this is a top priority, and that's why we're here today in the Martin Luther King, Junior, Auditorium, to focus on this issue, so we can take some of these facts and get them out to a broader audience and to the whole country, back to the Senate and to the Senate Budget Committee.

But all of you as well can take these facts out yourselves and to your own circle of influence, if you feel strongly about wanting to do something concrete about building a health care system that should work for everybody.

If that's what we want, we can have it. There are some people who want the Star Wars program, and they're pushing ahead mighty hard for that. And I would say that if there are more people in this country that want a real health care system that's going to mean something to everybody in this land of ours, then we can have that.

But we're going to have to say so and we're going to have to lobby for it, and we're going to have to work for it. If we do, then I think we can get it done. So I give you that thought to consider. [Applause.]

We have three more scheduled witnesses here, and then we're going to go to those of you in the audience who would like to speak. The first is Dr. Charles Vincent who is a professor at the Wayne State School of Medicine, and he is going to discuss from his vantage point the lack of insurance and how that discourages people from seeking regular medical care and how that often leads to far worse illnesses down the line.

Dr. Vincent, we are pleased to have you and we'd appreciate hearing from you at this time.

STATEMENT OF DR. CHARLES VINCENT, PROFESSOR, WAYNE STATE SCHOOL OF MEDICINE

Dr. VINCENT. Thank you, Senator. First of all, Senator, I'd like to welcome you and your staff to our city and thank you for sensitivity in having these hearings here.

I'm Dr. Charles Vincent, an obstetrician/gynecologist, president-elect of the Wayne County Medical Society and chairperson of the Michigan Board of Medicine. I'm also a practicing gynecologist in Steven Hospital.

I have the privilege of caring for women and children in this community. As a physician, one of my rolls is that of patient advocate—assuring those women who allow me to care for them to have a quality of medical care that's acceptable to both parties.

It has been stated that a society is best judged by how it treats its young and old. If this premise is agreed to, then we have failed so far.

I view access to health care as a moral responsibility for all Americans. It's a basic right, and yet it's currently denied to many Americans because of socio-economic problems.

I sat here with interest listening to the stories of the four people speaking before me in this case, but those are stories that doctors in this city hear every day 7 days a week constantly from patients, and it needs to stop. It needs to change.

At present, over 37 million Americans have no health insurance. Most of these people are women and children. Now, although many of them are employed, as you pointed out, the current trend is for employers to offer, quote, "part-time" employment, and therefore, to avoid the cost of paying for health insurance for their employees.

That Americans want good health care and will pay for it I think is well demonstrated by the fact that over 11 percent of our gross national product or $458 billion currently comprises our health care bill. So we will pay the bill for health care.

There's also no question but that we are a healthier Nation as judged by life expectancy. A baby born today has a life expectancy of 75 years. A baby born in 1900 had a life expectancy of 49 years.

So what is the problem? We're currently meeting in one of the largest cities in the wealthiest Nation on earth less than 1 mile from the largest medical school in the country.

It's located in one of the largest medical centers in the world, and yet within this same 1 mile, we have one of the highest infant mortality rates in the entire Nation, the highest incidence of commonly occurring cancers, teen violence, more homeless who abuse tobacco, other substance abusers, and other social ills that people in Detroit express themselves as disease than just the region can justify.

As a practicing physician, I can attest to our current health care policies, as jokingly in the hospital we call it No Cross. That's different than the Blue Cross and the Red Cross. It's No Cross.

I can certainly understand, although I don't agree with, the political dangers, in attempting to ration care in a market of rapidly escalating costs and new technologies. For politically, those who

are in the greatest need of services have little organized strength or power.

Now, it's not my intent to bore you with numbers or statistics as these are easily available through the local health departments and through the Michigan Department of Public Health.

Suffice it to say, the intricacies of quality health care involves three major components. They're inseparable, and they include biological factors, social factors, and behavioral factors.

It has been scientifically proven both in the United States and France that there is a direct relationship between education, income, health and life expectancy, and as you would surmise, those who are the least well educated have the lowest paying jobs, if they have any job at all, and therefore, no health plan. When illness or infirmity do strike, it's a catastrophic event.

In America, we've seen a shift from problems of infectious diseases. Where you look 50 years ago people died from pneumonia and things related to infections whereas today now social behavioral factors are the major roles in disease processes.

Smoking results in hundreds of thousands of Americans dying each year. The cigarette has only one use, and that is to smoke, and if it's used for its intended purpose, it will do only one thing, kill.

Misuse of automobiles, alcohol, other substance abuse account for 20 percent of the mortalities or deaths in the United States. It's estimated that another 48 percent of Americans die of factors related either to dietary habits or hypertension.

The adolescent pregnancy rate is intolerable, and although we are well aware of the eventual life style of the majority of these kids, it seem we look for an answer in better prenatal care rather than prevention of the problem.

We're well aware of who represents that unacceptable high infant mortality figure, and it is particularly frustrating to me for it is my community who suffers the most. That America with its wealth and expertise could rank 17th among western nations in infant mortality is deplorable. We're paying, but we're paying in lives and dollars for not being more aggressive in correcting that ill.

Community health needs continue to expand from AIDS and the legal implications resulting from testing and confidentiality, sexually transmitting disease, teen pregnancies, cancer and so on in an era where quality of care is being determined by the payor rather than by the provider.

I feel that one of the pivotal players in this game must be the physician, and he or she must react responsibly as both a friend and an educator. Unfortunately, the physician's role has been preempted by the health care administrator.

In the late 1960s, it was perceived that there was doctor shortage, and through political maneuvering, a capitation system to reward medical schools for increasing their numbers of graduates was established. We increased from 94 medical schools in the United States in 1965 graduating 8,000 students a year to 142 schools graduating 18,000 a year by 1982.

Some now fear a doctor surplus which is rather ironic when you recognize the fact that with the DRGs and other changes there's a

20 percent decrease in hospital admissions and physicians reporting over 6 percent decrease in office visits.

How can this have occurred in an era when we have such poor outcomes with regard to health care? The Association of Medical Colleges, recognizing the impact the shortages had on the black community, made a request of U.S. medical schools to increase minority enrollment from 2 percent in 1965 to 12 percent by 1986.

In spite of various affirmative action practices, we've not been able to achieve that goal. The allopathic medical at Michigan State University, the University of Michigan and our own Wayne State, and the osteopathic school at Michigan State all have effective recruitment programs but at the current cost of a medical education, which is approximately $15,000 a year, this makes it almost unattainable for most economically disadvantaged students.

In my experience it begins and ends with access to care, both the availability of physicians and the patient educated as to the appropriate use of that care. From a physician's perspective, three important events must occur.

One, the physicians must have as a part of their educational program an understanding of the interaction between the biological, social and behavioral factors of health to best educate their patients.

Second, Washington must deliver to its people a consistent method of financing said care as the current system of uncompensated care threatens most institutions which provide for the poor.

And third, Dr. Carl Gagliardi, president of the state medical society, polled its members as to the major impediment to health care availability—that poll indicated that nothing was viewed as more threatening to the current health care system than the current malpractice-maloccurance problems.

Physicians are refusing to give care for which they've been trained because of the threat of litigation. This impact is greatest in the areas of high risk, and therefore, the most disadvantaged communities again suffer the most.

Health care, like the atom or life, is in constant change. There's no doubt but that we in America have the experience, expertise, and capital to produce a health care system to serve all the people with quality care.

Thank you. [Applause.]

Senator RIEGLE. Thank you, Dr. Vincent. You state it very clearly and very helpfully to us, and I appreciate your commitment. I appreciate the fact that you are here and that you are making a difference, and I know everybody else here feels the same way.

Let me now call on Leroy Fahle, who is the chief executive officer of Mount Carmel Hospital in Detroit. He is going to talk about the problem of meeting the needs of people who are not presently covered by health insurance.

STATEMENT OF LEROY FAHLE, CHIEF EXECUTIVE OFFICE, MOUNT CARMEL HOSPITAL

Mr. FAHLE. Thank you, Senator Riegle. I very much appreciate this opportunity. You have our prepared text here. I think with

your permission I will depart from that to link with some of the comments that have already been made.

Senator RIEGLE. We'll make your statement a part of the record.

Mr. FAHLE. I work for an organization which has as part of its commission the commitment to seek out and serve the poor and the economically disadvantaged. In accordance with that mission, we have stayed in Detroit and made major capital investments in serving the citizens of Detroit.

In fact, our numbers equal 250,000 people served just this year. Those are substantial. It is becoming increasingly difficult to fulfill that commitment based on what's going to happen and the unfortunate circumstances that so many people do not fit a notch or a category that is defined for them in terms of our health insurance programs; and therefore, become not only victims of the system but they become dependent on that system instead of independent of a system and capable of making their own judgment.

This commitment continues to become increasingly difficult. We have responded to the Federal initiatives and some from the State and they would suggest access is important. We have built clinics to provide access.

They have suggested that aging services are important. We are into the aging in the nursing home business. We're in the hospice business. We're in the ambulatory care business. None of it is being adequately financed.

In fact, in the early segments of this, we find less money is being spent to serve those needs.

Our bad debts continue to creep up. In our hospitals alone, Mercy Hospitals in Detroit, Mount Carmel and Samaritan, last year's numbers were in excess of $11 million, not because people don't want to pay us, but because people don't fit the category or can't pay it.

We have responded to the need for outpatient surgery. Forty-four percent of all our surgery now is outpatient surgery. Outpatient surgery is not adequately compensated.

We are told to respond to these initiatives, but yet the debt is still there, and the obligations and the buildings are just as big as they ever were, and it isn't going to be any smaller.

We, too, share Dr. Vincent's concern about malpractice. In the city of Detroit, our costs are $10,000 per bed per year for malpractice costs. In the case of Mercy Hospitals of Detroit, that is $12 million, and we would just as soon spend the $12 million on helping people who are most in need than filling the pockets of attorneys who have very lucrative contingency awards associated with our malpractice system.

We would worry about being able to attract physicians to work with us in Detroit for that very same issue and to be willing to take the risk and to make the contributions where the levels of payment for physician services in urban areas lag far behind what they need to be to be able to make it an attractive opportunity for physicians who choose to work with us in meeting some of the special needs.

We worry about being able to deal with the infant mortality problem in partnership with physicians because, although some ef-

forts have been made recently in the State, we're only beginning to scratch the surface. We need to do more.

We need to find ways to make the people eligible for programs and provide programs that preserve their dignity. We need to find insurance options so people can make their own choices.

The testimony we've heard today suggests very strongly that people are very sophisticated consumers and ought to have the opportunity to make those choices and buy their services in a quality and in a compassionate context.

There are about 900,000 individuals in the State of Michigan without access to health care for private sector or publicly funded programs. Many of these individuals, as has already been pointed out, are employed. We need to be able to respond to their needs.

It's getting harder and harder to do what we are committed to do. Our bad debt I mentioned was $11 million. Our malpractice costs continue to be a problem. We need to find creative solutions to those. I know that they're a Federal initiative, but I think that employers ought to be required to provide insurance coverage to their employees regardless of their employment status.

We need to find Federal incentives that provide opportunities for persons to get health care coverage and keep it even if they change jobs. Coverage is where we need to provide it, not the reimbursement side. I want the money, but I want the people who come to us because we're a quality institution, to come to us with freedom of choice because we're a better hospital than whatever other hospital they need to be in.

I would conclude my remarks by saying that we will continue our efforts and we hope that your recent initiative will help us to fulfill our goals in the future.

Thank you, Senator.

Senator RIEGLE. Thank you very much. [Applause.]

[The prepared statement of Mr. Fahle follows:]

SISTERS OF MERCY HEALTH CORPORATION

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STATEMENT

by

LEROY D. FAHLE
President and Chief Executive Officer
Mercy Hospitals and Health Services of Detroit

Mt. Carmel Mercy Hospital Unit
Samaritan Hospital Unit

before

THE HONORABLE DONALD W. RIEGLE, JR.
United States Senator

on

THE CHALLENGE OF PROVIDING HEALTH CARE TO THE POOR

November 11, 1987
Martin Luther King High School
3200 East Lafayette
Detroit, Michigan

INTRODUCTION

Senator Riegle, I am LeRoy Fahle, President and Chief Executive Officer of Mercy Hospitals and Health Services of Detroit, a voluntary not-for-profit provider of health care services which is sponsored by the Religious Sisters of Mercy, Province of Detroit.

I very much appreciate this opportunity to provide you with my views on some of the challenges we are facing in providing health care benefits in the current milieu. Let me first give you some brief background about our health care services and their scope.

Mercy Hospitals and Health Services of Detroit, a division of the Sisters of Mercy Health Corporation, comprises the Mt. Carmel Mercy Hospital Unit in Northwest Detroit and the Samaritan Hospital Unit on Detroit's East Side. These hospitals combined have almost 1,000 beds. About 450 physicians have privileges at these two hospitals. Annually Mt. Carmel serves about 86,700 individuals while the comparable figure for Samaritan is 130,500. Both hospitals provide 24 hour a day emergency care, and last year the two hospitals combined saw approximately 81,100 patients in our emergency rooms.

The Sisters of Mercy Health Corporation has a long tradition of providing health care in Detroit. Our roots are here and our commitment to the area is permanent. A testament to that commitment was the opening of the new Samaritan Hospital in 1984, at a time when many health care service locations were, for financial reasons, being relocated in the suburbs. This investment was made for the purpose of increasing access to health care services and increasing the quality of services we are able to provide. Samaritan is a 375 bed acute care hospital which was completed at a cost of $86.6 million. The debt service on this hospital represents about 18 percent of the total corporate debt.

Operating in tandem with these two hospital units are five primary care health clinics which have been providing health services in the City of Detroit since 1979. The locations of our hospitals and health clinics mean that we are accessible to just about all of Detroit's one million residents and many of those in its environs. The annual operating budget for all five of these clinics totals about $7 million. Of this total, about $3 million comes from Federal support. While we do receive reimbursement of about $0.6 million for the services rendered at these sites, about $2 million provided is charity care, and $1.4 million is bad debts. Clearly this is not a breakeven situation. While we have reviewed and moved forward on plans to open a sixth Detroit site for primary care services -- the indicators all point to a strong need for services in the area -- the estimated losses from the expansion of this operation may be beyond our ability to absorb, given the overall financial costs of providing health care coverage relative to the revenues that we are able to realize from these operations.

Our primary care facilities provide health care services for about 8,700 patients per month, although the most recent monthly count has exceeded 10,000, attesting to the sharp increase in the need for such services in the City and to the diminution in the availability of services to Detroit residents from private physicians.

RECENT HOSPITAL CARE TRENDS

Throughout the seventies we witnessed increased health care costs, including longer inpatient stays and investment in new facilities and technology. Concern with the rising proportion of income that consumers and their employers were expending for health care services brought about a sharp reversal of these trends in the eighties. While many of the changes we have seen have been socially good and in our patients' interests, they have resulted in serious cost pressures. Let me elaborate.

From the early to mid-eighties inpatient hospitalization days for residents in Southeast Michigan dropped from 1,308 to 1,095 days per 1,000 population. Concomitantly, outpatient admissions in this geographic area increased by almost 9 percent, while the increase in outpatient surgeries increased by 126 percent. Overall, the number of surgeries performed in our hospitals has remained about constant in the last five years.

However, outpatient surgeries now comprise 44 percent of total surgeries compared to 19 percent at the inception of the decade. Put another way, for every ten surgeries performed on an inpatient basis in Southeast Michigan five years ago, three are now performed on an outpatient basis. In general, this has meant quicker recovery for patients and the ability to recuperate at home.

Needless to say, this trend has necessitated that we reconfigure our hospitals to account for the increased outpatient complement, even though our remodeling in the seventies and early eighties was predicated on increased inpatient days and longer stays per patient. Currently, our average inpatient occupancy is running about 53 percent and 61.5 percent at Mt. Carmel and Samaritan, respectively, compared to a 1980 occupancy rate of 90 percent and 68 percent based on licensed beds. The trend towards fewer inpatient admissions and greater numbers of outpatient procedures means that we are amortizing an indebtedness and maintaining a capital facility based on medical practices of several years ago, yet receiving revenue on today's far more constrained basis.

Driving our need to increasingly focus on cost cutting at the same time we must focus on the health care requirements of the population we serve is the steep, and evidently continuing and inexorable, increase in medical malpractice costs. For our two Detroit hospitals, we annually must contribute about $12 million to our Corporation's hospital medical malpractice trust fund. This cost complement is in addition to what physicians pay for medical malpractice insurance coverage.

Recently the Michigan Hospital Association compiled data to put the 1986 cost of medical malpractice coverage for hospitals in Southeast Michigan in perspective. This study found that the base rate for a $1 million/$3 million mature, claims-made medical malpractice insurance contract for a small rural Michigan hospital is higher than a major teaching hospital located in New York City or Chicago. The annual cost for the hospital in rural Michigan is about $5,000 per bed while the comparable costs are $3,000 and $2,600 in a major teaching hospital in New York City and Chicago, respectively. And, most notably, the comparable cost in the City of Detroit is about $10,000 per bed, certainly among the highest, if not the highest, medical malpractice rates in the nation. We predict that these figures will, at least for Detroit, continue rising into the foreseeable future.

RECENT PHYSICIAN CARE TRENDS

Hospitals cannot accomplish their mission without physicians and, as I previously indicated, about 450 physicians have privileges at our two hospitals. While I already outlined some of the pressures our hospitals find themselves in, I would be remiss if I did not indicate to you the exigencies being faced by physicians who practice at our two hospitals. A physician who seeks privileges at our hospitals does so with the reasonable expectation that he or she will have the opportunity to maintain and enhance his or her expertise as well as receive reasonable remuneration for services rendered from the patients he or she sees.

The scope of the services we provide and the health care needs of the population we serve both provide the base for a physician to enhance his or her expertise. Let me cite some illustrative examples. Each year we receive 1,500 applications for 6 residency positions for emergency medicine; over 2,000 applications for 10 residency positions for internal medicine; almost 1,000 applications for 6 residency positions for pediatrics; almost 1,000 applications for 6 residency positions for surgery; and 400 applications for 3 residency positions for orthopedic surgery. These requests attest to our ability to provide physicians with the opportunity to secure the expertise they need. Our challenge is to encourage them, after they conclude their residency training, to set up their practice here, despite some of the financial uncertainties they will face in this area.

Let me identify some of these uncertainties. As with hospitals, medical malpractice costs must again rank high on a physician's list of concerns when deciding where to locate a medical practice, especially for those physicians who choose to make their careers in what are termed high-risk specialties such as obstetrics, neurosurgery, anesthesiology, etc. Currently a Detroit obstetrician must, in some cases, pay $70,000 and more per year for $200,000/$600,000 coverage, an extraordinarily high premium for the coverage provided. Again, these are some of the highest rates in the country and they show no signs of leveling off in the near term. If each of our 450 physicians pays an average of $20,000 a year for coverage, this totals $9 million and is in addition to what hospitals pay for such coverage. Not all of the coverage purchased by these physicians is for liability protection for services in our two hospitals, but these figures do illustrate the extraordinarily large funding required to secure this coverage.

Let me turn now to another issue facing physicians in their decision to provide health care coverage in urban areas. I am certain that you have heard, Senator Riegle, that Detroit has an infant mortality rate of about 21 per 1,000 live births, about double the national rate. The entire Detroit health care community is facing this challenge and working together to assure that pregnant women who need prenatal care and other necessary services receive them. The evidence is overwhelming that if such women receive this care and follow appropriate medical instructions, they stand an excellent chance of delivering a healthy infant. Needless to say, physicians are integral to this process of reducing Detroit's infant mortality rate.

I am happy to report that Michigan has taken advantage of the salutary provisions in the supplementary Omnibus Reconciliation Act of 1986 (PL 99-509) that permit states to provide Medicaid benefits to pregnant women whose incomes are at or below the poverty level, significantly increasing the number of women who are eligible for Medicaid services during their pregnancy. It is estimated that an additional 3,000 women per year in Michigan will be eligible for pregnancy-related medical services as a result of the State's expansion of Medicaid eligibility for these women. This expansion of services not only covers health care services but also includes education, transportation and other social services. The State also has expanded Medicaid eligibility to children up to age two who are in families whose incomes are at or below the Federal poverty level. Medicaid, however, pays physicians only about $500 for a delivery without complications. In the face of the malpractice situation in the State, this payment is far lower than what is needed to amortize one's expenses.

RECENT PATIENT CARE TRENDS

However desirable the adoption of this new Federal option may be to individuals who have low-wage employments, there still are thousands of individuals who are not eligible for health care coverage programs from their employers or who are unable to procure coverage from a health care insurer or health maintenance organization because of its cost, inability to find an insurer to sell the coverage, or medical underwriting strictures.

Employment and family composition stability is a reality which has all but vanished from the urban scene. One family member with a full-time job supporting all the rest of the family members has, in many families, been replaced with interruptions in labor force participation, part-time and temporary jobs, and irregular work schedules to accommodate the changing economic conditions and varied needs of families. These trends have been overlaid with employers' aggressive attention to health care cost containment and insurers' pursuit of severe underwriting strictures on health care coverage. This confluence of events has increased the number of individuals and families without access to any third-party payer for health care coverage benefits, even for those having adequate financial means to pay for health care coverage.

Individuals without health care coverage and who are not eligible for Medicaid or assistance from other public programs pose an almost overwhelming challenge to our institutions -- and a challenge that all indicators suggest will continue trending upward. While not statistically quantifiable, we

believe that many of these individuals forego routine preventive care and forestall needed treatment. These twin phenomena result in increasing visits to the emergency rooms of our hospitals and an increase in inpatient admissions through our emergency rooms. And it goes without saying that these individuals are unable to afford the cost of the care that is rendered to them.

As you know, it has been estimated that there are about 900,000 individuals in the State of Michigan without access to health care through private sector or publicly-funded programs. Many of these individuals are employed and it can be projected that more and more individuals without health care access will be among the households where more than one individual is employed.

Despite the fact that most individuals seeking health care at our facilities have every intention of paying for it, many of these individuals without access to a health care coverage program end up on our bad debt rosters. The bad debt complement at the end of the most recent fiscal year totalled $4.7 million and $7.1 million at Mt. Carmel and Samaritan, respectively, despite our aggressive pursuit of these monies and our development of payment plans for individuals not able to make payments in one total lump sum. Our charity care demands, which we budget in advance on an annual basis, also have increased in the past several years.

Physicians face dilemmas similar to that faced by hospitals under these circumstances although their more limited and more mobile capital investments

probably makes it easier for them to "vote with their feet" and leave the local area if it appears that remuneration for services is being reduced and their bottom line is being impinged by cost constraints. While it is painful for us as a hospital to pursue individuals for payment of their health care indebtedness, it is even more painful for a physician to pursue similar claims because of the often very personal relationship that the physician has with the patient. However, with the increasing number of physicians having significant bad debt rosters, the greater the need for physicians to pursue bad debts in order to make a reasonable rate of return. Let me turn now to options that may be considered to alleviate these problems.

OPTIONS

Michigan has had a long tradition of assuring that its residents have access to adequate health care services and I am certain that were it not for the strictures of the Federal Employee Retirement Income Security Act (ERISA) of 1974, the Michigan Legislature would actively be considering health care mandates for the working population. The Michigan Legislature has provided health care benefit mandates for victims of automobile accidents and those injured or incurring diseases that arise out of or in the course of one's employment. As you know, Michigan's automobile drivers must by law purchase first party medical benefits and these contracts must not be limited in duration or amount, a requirement that is unique among the fifty states. The same mandate is true for employers who must purchase or have a state-approved workers' disability compensation self-insurance program.

We must, however, look to the Fedaral Government for a solution to the problem of the increasing number of working-age individuals without health care coverage benefits. We have in process in Michigan, as you know, a pilot demonstration project being implemented in Genesee and Marquette counties that will provide subsidized health care coverage benefits to low-wage employees. One of the purposes of the project is to test what incentives are needed for employees to purchase and for employers to subsidize health care coverage. Should this study conclude that, with reasonable incentives and an affordable governmental subsidy, employees would opt to be covered by an employer-sponsored health care coverage program, the Michigan Legislature could not expand the program by mandates because of the Federal law's barricade.

While I believe that a Fedaral solution such as Senators Kennedy's and Weicker's S 1265, which would mandate employer-sponsored health care coverage for a very large percent of the working population and their dependents, is far preferable to a state-by-state patchwork solution, there must be forthcoming Federal legislation that would at the very least give states the ability to craft appropriate health care access programs for their own population. I realize that states which utilized such Federal options to provide health care coverage might find that businesses would choose to locate or expand in competitor states; however, these differences can be neutralized through the Federal tax structure.

Incentives provided by the Federal Government to the states must go beyond the Medicaid program and could include such options as a required offer to employees by employers of health care coverage programs; mechanisms for

portability so that those switching jobs do not have to incur pre-existing conditions exclusions and waiting periods; mandates that HMOs, blue cross organizations, and health insurers actively market and offer health care coverage programs to employers and individuals as a condition of licensure; appropriate purchase options for individuals against whom insurers currently medically underwrite; options to utilize the Medicaid program to provide subsidized coverage and to design cost containment features so as to increase access, etc. Federal incentives must be crafted so that one of the penalties of working is not loss of access to health care coverage. Too often, the transition from welfare to work means a marginal tax rate of well in excess of 100 percent as health care coverage is no longer provided. Senator Moynihan's welfare reform measure offers the opportunity to develop appropriate incentives to those transitioning from welfare to work.

I personally believe that programs aimed at the coverage rather than the reimbursement side of the equation will prove more efficacious in widening the number of individuals who are eligible for health care coverage. Programs that redistribute existing funds among providers may be counterproductive and even reduce access, especially if some providers believe that it may be in their best interest to pay their tax rather than utilize their resources in providing indigent care.

SUMMARY

These experiences and trends over the past several years, as you might expect, have not only impinged and disrupted hospitals' operations but also

has changed our employment complement and requirements as well as imparting instability to hospital employment. Young people making career decisions are aware of these factors and fewer and fewer are choosing nursing, physical therapy, and other vital health care careers, making it difficult for us to maintain the employment complement we need to serve our patients. This trend is heightened in urban areas where we often are put at a competitive disadvantage relative to hospitals located in areas where similar opportunities are offered but where the living and other expenses are lower.

I and the rest of the Mercy Health Services family look forward to working with you on these challenges.

Senator RIEGLE. Now, Sidney Rosen, the head of Detroit's Senior Citizens Department. We are pleased to have you and we'd like to hear from you now.

STATEMENT OF SIDNEY ROSEN, DIRECTOR, DETROIT SENIOR CITIZENS DEPARTMENT

Mr. ROSEN. Thank you, Senator. I hope I could have the opportunity to add these comments to be included in the record.

Senator RIEGLE. We'll make it part of the record, yes.

Mr. ROSEN. My name is Sidney Rosen, and I am the Director of the Senior Citizen's Department for the City of Detroit. I am a senior citizen and I have been on the job as Director for the past 13 years. In the years that I have lived, and I am proud to admit that I am 82 years of age, I have witnessed and been involved in many changes that have taken place in this Nation. I can recall when there was no program like Social Security; when older people were no longer able to work because of age, and if they did not have savings they would be sent off to the "poor house". When a family or person needed medical services they had to pay out of their pockets if they had it, or were forced to seek some charity to assist them. We have come a long way in this society, in spite of the efforts by some in high places to take us back to that kind of society, particularly as it relates to human services and a guaranteed income.

For those of you too young to know about Social Security, the base for this program was to provide some assistance for older workers and some way to insure that widows and children could be cared for. I can remember a time when there was no program like Social Security that provides a minimum income to insure against workers growing old and not having savings or any financial means to care for themselves in their senior years. Just a few short years ago, those of us who are senior citizens had to marshall all of our resources to fend off the attack upon Social Security. We were painted as costing this society money, laying claim to human resources of more than a fair share of the Nation's resources for domestic programs. Senior citizen services were pictured as part of the national budget deficit by Mr. Reagan; and younger workers were repeatedly told that we were using up all the benefits to such a degree that there would be none left for them when they reached their senior years. In truth the problems that we face today are directly attributed to the executive branch and the acquiescence of Congress to Reaganomics. Congress is not totally to blame nor is Mr. Reagan. We, the citizens of this Nation must also share the responsibility for the conditions we currently face. We elected twice a man who demonstrated limited understanding of the management of government, whose reality is centered around a "Rambo" view of the world; and whose sensitivity to the needs of people in this Nation is limited to a concern for what he calls ". . . the welfare cheats" living on the dole.

I want to express my sincere appreciation to Senator Riegle for hosting this conference on catastrophic illness. It is becoming one of the real fears among the elderly. My department operates an Information and Referral Project that is funded by the local Area Agency on Aging. This project seeks to provide information to

senior citizens in the city as the services and location of services specifically oriented for senior citizens. From our reports and inquiries, it is clear that health care along with housing is becoming one of the very critical areas that is negatively impacting upon older people.

From a personal experience I have come to know more acutely the kind of problems and costs associated with health care. Like many people I thought I had adequate coverage for medical services for myself and my wife. We both get Medicare and we both have insurance policies to cover all other considerations.

Unfortunately, she has a medical condition that leaves her mentally alert, but highly immobile. One expects that with medical insurance the kind of out-of-pocket expenses would be minimum. My wife's care requires that home care is part of the daily routine. This means that for approximately 8 hours of every day someone must be available to assist her in moving about to attend to personal needs and care. This expense is not covered because it is not part of our insurance coverage and ranges in cost about $6 an hour for a five day period. When there developed an emergency problem with her health, she was taken to the hospital and not fully admitted because the Diagnostic Related Grid (DRG)—I think there would be another name for it there but I think it would be repugnant to you if I were to express it, but it is something that we have been foolin.g in. We don't even understand what it is. It is supposed to cut down costs. It is supposed to make medical care more efficient, but it does just the opposite—indicated that she had previously expended the length of time for her illness already. That evening my wife was confined to the emergency treatment room. I might add that it was only because I demanded that she be allowed to stay. My wife has a chronic illness. It did not appear to make any difference that if she were sent back home, she might have to be brought back in a few hours. This is a scenario that too often is played out for older people and who are too frightened to know how to deal with this problem.

The changes in the composition of the Nation's population has long been spoken to and written about by demographers and population experts. We have a growing aging population and this rise in the senior population will and has already begun to dramatically alter the society. Older people are living longer and in many ways, we have to thank our medical community for the many hundreds of advancements that have contributed to this longevity. What has not been occurring with equal growth patterns is the kind of supportive services and modifications in the delivery systems that growing numbers of older people will require in coming decades.

With advanced years, and I can speak from a personal point of reference, health care and ancillary services will be required for a senior population. Health care is one of the very costly commodities for many elderly and is an area that must be given real attention. The enactment of the Diagnostic Related Groups (DRGs) without recognition of the inherent problems and possibilities of death and further health problems for the elderly has been the short sightedness and insensitivity demonstrated by the Department of Health and Human Services.

It is important to say that no one can or should complain about the need to find ways and methods for cost containment within he medical health care services. It is true that health care cost has become excessive and very expensive. Unfortunately, the solution to the cost of health care has been at the expense of victimization of patients who need the service and at a point of highest stress, when the patient needs the health service.

This Nation has the capacity, as one of the most advanced technologically oriented nations in the world. We rank so very low in terms of health care provided to our citizens. Most industrialized nations and many underdeveloped countries provide better health care for its citizens. One might well ask why?

The answer is very simple. We do not have a national health care policy. We do not have minimum standards for health care that should be available to every citizen, growing numbers of who are and expect to become senior citizens.

Another reason and perhaps the more compelling one is that our health care system is now part of the market economy. If there is no money to be made or profits to be gained, then health care is viewed as another socialistic trend that is bad for the Nation and leading us towards the horrors of Communism. There are many rational people in this Nation who sincerely believe that, and unfortunately one such citizen currently occupies the highest seat in the land—the office of the President.

Health care is more and more becoming a privilege and not a right extended to citizens. In the meanwhile, people living on fixed incomes and that includes the middle classes as well, a good number of whom are elderly and retirees, live in fear of becoming chronically ill or having a spouse become ill and requiring expensive treatment over a long period of time.

The shift in health services has become an industry, has been the result of three complementary forces; changes in technology, changes in financing, and changes in the prestige structure of the medical profession. Medical care has become a vastly specialized profession and more and more dependent upon technology and an institutionalized major center.

These major health centers are equipped with the latest hardware for sophisticated testing, access to research and newer techniques, diagnostic procedures and an array of resources that no single practicing physician could possibly afford. Additionally, the complement of a specialist to assist with diagnostic assessment, and laboratory testing possible, has served to make major advancements in health care. These are the very positive outcomes that have emerged over the past 40 plus years, and is one of the more positive features of our current health care system. This consolidation, fostered by several factors, has contributed to the development of what can be viewed as our current health care empire.

This centralization of health care delivery around hospitals and the role assumed by medical insurers which allowed for the concentration of expensive equipment to be housed in central or major hospitals gave rise to the development of hospital equipment industries. Medical insurers forced and continue to do so, the merging of smaller hospitals with major ones or left outside the mainstream of medical technology.

The problem for the Federal Government has been to try to restructure the delivery system of health care so that it is more efficient and cost effective. This move has come after years of fostering hospital expansion through the Hill-Burton program of post World War II and large outlays of funds that flowed through the system from Medicare and Medicaid. Today's health empire is interlocked with health financing institutions, government, and health commodities that include hospital equipment industries and pharmaceutical companies. It is easy to understand that a quick answer to runaway medical costs is of serious concern to all of us. The DRGs, no matter how well intended, do not account for the differences individually among people and make no distinction between younger patients and the elderly.

There must be a balance established that accounts for differences in age and individual stamina. Otherwise the punitive punishment of the elderly will continue and the blame for high medical costs will be hidden and not fully examined.

There appears to be or so it would appear no way to insure that medical care costs can be controlled because no one wants to address what is essentially a national health care law. Until we recognize that profits as an incentive will continue to drive up the costs our anger, frustration and crying about health care will continue and our elderly will be victims—no matter what their economic circumstances are.

Senator, I thank you for this opportunity to allow me and others here to speak, and I look forward to working with you and others as we try to work for meaningful legislation.

May I add one more statement?

Senator RIEGLE. Yes.

Mr. ROSEN. Yesterday in the New York Times there was a letter written by a Mr. Jim Hechtman, who is connected with the Bergen County Gray Panthers. I think it is worthy because of the topic. I will just read part of it.

> The Reagan Administration made a safety net from loose string and gauze. Your editorial suggestion to treat Social Security benefits as ordinary taxable income destroys even that flimsy thing. You note that "only couples living on more than $32,000 pay income taxes and then on only half their benefits."
>
> Most of the people on Social Security are not, as you put it, largely "largely middle- and upper-income retirees." There is also the unsolved problem of workers who must continue employment to maintain some standard of living. Their income taxes continue; their Social Security taxes continue, but their contributions are not rewarded by any increases. The United States debt can be solved. Remove the $700 toilet seats and the $300 hammer. Remove the swollen Pentagon appropriations. Stop their frantic efforts to spend their absurd grants so that they can ask for more."
>
> Social Security is not an entitlement! The working people of this country have paid for it all the way. And it is not part of the national debt!

Thank you very much.

Senator RIEGLE. You'd be interested to know, Sidney, that I gave a speech on the Senate floor last Friday on Social Security along those lines because there was talk about sneaking cuts into the budget package. Some people think that by cutting Social Security or the COLA adjustments, that will somehow solve the Federal budget deficit.

Well, that's just untrue, and I think we've stopped the current attack on Social Security, but I'm determined to stop it if I see any more sign of it. You can count on that. [Applause.]

Let me thank our panelists here. We are going to move along because we got a number of people that have asked to speak. Let's give all of our panelist one more round of applause. [Applause.]

Now, a number of people have asked to speak, and I'm going to call off the first five names. The panelists are welcome to stay. I don't want you to feel like you have to stay in those seats unless you wish to. So please do whatever is most convenient for you.

I am going to now call on the other people in the audience who have asked to speak, and go in this order. I'm going to call off the first five names, and then I have to give a minute to the gentlemen from WWJ who wanted a comment here. So I'll do that before our first person speaks.

But our first speaker will be Commissioner Jackie Currie. Then Sandy Thompson. Then Mrs. McCullough. Then Gordon Herron, and then Gerald Haran, and then George Pollak. Then Gorden Andrews. We'll go in that order.

[Recess.]

Senator RIEGLE. Let me again thank all of you for coming today and for your attendance and your patience. Commissioner Jackie Currie, we'd be pleased to hear from you.

STATEMENT OF JACKIE CURRIE, WAYNE COUNTY COMMISSIONER

Ms. CURRIE. First I'd like to say good afternoon, and I'd like to thank you, Senator, for coming into Wayne County to have this hearing. We're all concerned about health care. As you know, when you read the paper, you do know we have some problems in Wayne County.

We have Commissioner Kilpatrick here who is working very, very closely with the health care program and who is also the chairman of our health care committee, and I'm going to let him speak next.

Mr. Bernard Kilpatrick.

Senator RIEGLE. Bernard, we'd be pleased to hear from you.

STATEMENT OF BERNARD KILPATRICK, WAYNE COUNTY COMMISSIONER

Mr. KILPATRICK. Thank you, Senator. Thank you, Commissioner Currie.

With your indulgence, I would like to introduce one of our newest colleagues from the east side. Commissioner Alberta P. Williams.

As Commissioner Currie said, I'm chairperson of the Committee on Health and Human Services, and I'm also chairperson of the Wayne County Executive Task Force on Infant Mortality. So a health care hearing of this sort is very close to me.

I have been a long-time supporter of Senator Riegle, and we are lucky to have a fighter like Senator Riegle in town. As a legislator, I understand that he has been trying to get a national health care

program, and like the gentleman who spoke earlier, there is no health policy and it becomes difficult.

I think on the local level, however, we can do some things that can help in the situation in which we find ourselves, and in Wayne County there is no strong responsibility for uninsureds. So when you see in the paper that Wayne County is broke all the time, basically we're broke because of health care, and that is not an exaggeration.

We're not losing tax base, and the uninsured, that group is getting larger and larger, and there are some test cases in court now that if the counties lose, their going to break some small counties because of health care. I mean, they will send them into receivership.

So when you read about Wayne County, most of our problems stem from health care. For instance, last year we budgeted $12.5 million for safety and $19 million and $31 million. It cost us $54 million. So that was $20 million that we owed the State that went into the hole. This year we're projecting $62 million.

What we're doing now is working on a program where we combine the GA programs and what we call our RCA, our resident county hospitalization. Dr. Vincent, who really gave a good speech that you could give on health care, mentioned about preventative health care.

By joining these programs together for the first time, hopefully if it passed the State legislature, we will be able to offer some outpatient care. As any of you know who don't have a job and are uninsured, that basically the county takes care of you only on an emergency basis. If you're sick enough to go into the hospital, then we can take care of you.

But outpatient care, the preventative aspect of health care, has heretofore been very difficult. Even those folks who are on GA have a very difficult time receiving outpatient care.

If this package goes together through in Lansing, and we have very high hopes for it, for the first time GA recipients and RCA, poor folks, would have preventative health care. We're going to make up a health maintenance organization type of thing, a PPO or HMO, some kind of system where we can finally begin to manage this population.

That's the only thing we can do on the local level while we're waiting for fighters like Senator Riegle to hopefully move the legislators and other Congressmen to come to grips with some real solutions which is a national health care policy.

Thank you very much. [Applause.]

Senator RIEGLE. And I thank you. Thank you for your leadership.

Almost a year from today, actually a year from yesterday, we're going to elect a new President in America. Everyone whose got a voice and everyone who has a vote is going to have something to say about who that will be and whether that somebody is committed to doing something about this health care problem.

So an occasion is coming where we can have a real say about the direction of the country for the next 4 years.

Sandy Thompson.

[No response.]

Mrs. McCullough?

Before you start, let me just say one thing. We have the auditorium until 5:00. It is now 3:00. One thing I am going to ask is that everybody try to condense your remarks and just lay it right out so that we have enough time to get through the whole list.

STATEMENT OF MS. McCULLOUGH

Ms. McCULLOUGH. Senator Riegle, I want to say I am Ms. McCullough, not Mrs. McCullough.

I want to say that I have written you a letter, but this I would like to add because I didn't know about your proposal, and about this proposal on Medicare, this catastrophic, loss protection. Now you say if this passes, then if we have other insurance that we can drop it.

I've been saving for 35 years, and now I'm at the retired age, and I would like to stop work, but I can't stop working because I have to keep working whenever I can to keep things moving and keep a roof over my head.

Now, if this bill passes, will I be able to drop my insurance? What kind of Medicare service will I get and would I be able to use the same hospitals and the same doctors?

Senator RIEGLE. Well, yes, you would be able to use the same doctor and the same hospital, and in all likelihood, you will be able to drop your private Medigap insurance, since that insurance is usually added on to your Medicare to cover major hospital illnesses.

This extension of catastrophic health insurance under Medicare would cover that, and so if you're buying private insurance today to cover that very same kind of thing, you would be able to discontinue your private coverage since you'd be getting it now through Medicare. I assume you are currently covered by Medicare. Is that right?

Ms. McCULLOUGH. Yes; I just wanted to know so I would not have any problems.

Senator RIEGLE. Yes.

Ms. McCULLOUGH. And Blue Cross is very expensive, and I don't know how long I'm going to be able to keep it. And it bothers me.

Senator RIEGLE. If you have Medicare coverage now, and I gather you do——

Ms. McCULLOUGH. Yes, and Blue Cross.

Senator RIEGLE. If you're carrying Blue Cross in order to provide this extra coverage for a catastrophic illness that would take you into the hospital with big hospital and doctor bills, this new protection covers that very substantially.

Now, I mentioned earlier that $1,850 a year would b ' the maximum that you would have to spend even if you ran up ' ills a quarter of a million dollars in a year. I don't know what you're paying for your private insurance, but you're probably paying that much or more per year.

Ms. McCULLOUGH. $89 every two months.

Senator RIEGLE. I have an office in the McNamara Building, and I'd like to take a look at your coverage to see exactly what you're getting and what you're paying so we can compare it with this new

coverage. That way I can really give you an informed judgment as to whether you can discontinue the other coverage.

Most people will be able to discontinue their Medigap coverage, and you may very well be able to discontinue it yourself. If so, you would have a saving in that area. Now, the cost of this other insurance is going to be a $4 a month charge. It's a $4 a month charge that will be automatically deducted from your Social Security.

But next year there's going to be a cost of living adjustment so your Social Security benefit is going to go up. Part of that will then be transferred to pay for this $4 a month charge for catastrophic health insurance.

But that will be a real bargain because you're going to be part of a great big insurance pool, and that's why we can afford to do it for less money. So why don't you bring your policy in and let us take a look at it so I can make sure that you understand exactly what the tradeoffs are before you discontinue Blue Cross.

Ms. MCCULLOUGH. I certainly will come. If you're buying medicine and once you pay the insurance, you don't have money to buy medicine.

Senator RIEGLE. I realize that. It's a real problem.

Ms. MCCULLOUGH. Thank you very much.

Senator RIEGLE. Thank you for coming and thank you for your comments.

Mr. GORDON HERRON. And then Gerald Haran and then Doris Sieffert is going to speak for George Pollak.

STATEMENT OF GORDON HERRON

Mr. HERRON. Senator Riegle, I have shortened this speech as much as I can. Frankly, 5 years ago I retired. I'm 67 now. I retired at 62. And I worked in construction most of my life, and at that time, we thought we'd have health coverage, dental and eye care for the rest of our lives, the rest of our retirement.

Well, I think you're all aware that recently during this 5-year period that most of these things came to a halt. They started stopping your dental care which, for instance, they have to put something metal in my jaw which holds my tooth which gets very expensive. I have that charge now.

When the dental care stopped, the health insurance did not stop, but they said that we could still have our health insurance, but if we wanted it, it would cost us $256 a month. Now, that happens to be with a construction local here in the city. The unions want a general increase.

This really points out because one of the things that you're mentioning in the thing about national insurance was about uninsured and underinsured. On top of what I just mentioned, just these past few days my wife and I have been working on trying to figure out what we're going to do next because we received a letter that when we were told of the $256 a month insurance from my construction job that they are going to go over to a HMO type thing, and they were acquired by a health and life company very recently.

So I received a letter saying that our premium for health insurance was being doubled come the 1st of January of 1988. That got me moving in a hurry. They're increasing the co-pay from $2 to $5

each, and that is paid to the doctors. We can't go to the same doctor the way we've been used to.

From what I figure, these things have changed every 12 months because of a provider and an insurance company decided not to do business with each other. The talk in our homes was that if it doubles one more time then hardly anyone can afford the insurance.

Now, I think I covered that pretty well except a few figures here. Starting the 1st of January, 1988, there will be a $54 a month increase in insurance premium; an increase of $22 in what we pay for prescriptions; an increase in Part B Medicare for my wife and myself. That will be $89.80 a month increase for our health care. That's some money.

Right out of my pocket that comes to $2,335.20 a year, and when you add the money put in by Medicare on top of what's taken out from Social Security, it ends up to $2,930.40 a year that goes into our health care. I wonder what it's going to be in the next 5 years.

Senator RIEGLE. That's a very frightening summary but an accurate one, and it's a very important statement for us to have in the record, and I appreciate your taking the time to come down and give us those figures. It is very distressing to hear.

Mr. Haran.

STATEMENT OF GERALD HARAN

Mr. HARAN. Thank you, Senator Riegle, for having us come here today and express our opinions and ideas on health insurance. Just listening to the various people who spoke here today, I must say I must echo everything they have to say about health insurance.

We need health insurance for the people of the State of Michigan and we need it now. We can't wait for the politicians and everyone else to provide health insurance for our people. We need support and we need it now. [Applause.]

My name is Gerald Haran, and I live in Novi. I am associated with 37 organizations in the Tri-County area. I am an advocate for the hungry and the homeless, the poor, the unemployed, and the disadvantaged.

I worked 25 years for major corporations, and I've seen the way they took care of their people, and I say there's got to be an end to it. [Applause.]

The poor don't have health insurance because they can't afford $200 or $300 a month. In the State of Michigan alone, we have hundreds of thousands of people who have no health insurance and no way of getting it.

The large automotive companies are gradually cutting out health insurance for their workers. In the last year that I was with General Motors they spent more than $2.5 billion on health insurance and projected to be $10 billion by the mid 1990s.

The word came down from Roger Smith, we have got to do something about health insurance costs. And what are they doing about it? They're allowing people to work part-time with no health insurance benefits. They're putting probationary employees on. It takes you a year to get health benefits.

They're terminating their people without providing health insurance benefits. They've got flexible employees with no benefits.

That's only one company. But it provides one out of every eight jobs in the State of Michigan.

The Ford Motor Company, the second largest company in the State of Michigan in terms of automotive, just cut out their vision and dental coverage for the salaried work force. It was in the Free Press the other day. That's going to save the company billions of dollars, but the people are going to be out there without any health insurance benefits.

In a country where you have such prosperity like the USA, millions of people go to bed every night not knowing if illness strikes how they're going to pay for it. Thirty-three million people live below the poverty level in this United States.

For the senior citizens, Medicare has turned into a farce with its deductibles and co-insurance. What about prescription drugs? Who is making the money? The pharmacies and the doctors. That's who is making the money. [Applause.]

Last year the Gray Panthers approached me about bringing a proposal to Governor Blanchard that was similar to the Ontario health provincial plan. It would provide uninsured people in the State health insurance.

I gave that proposal to the executive secretary of Governor Blanchard who then gave it to Governor Blanchard. I also gave a copy to Mr. Coleman, the State Commissioner of Insurance. One year later we don't have that proposal in effect here in the State of Michigan.

We've got to do something, Senator Riegle, and as I say, we've got to do it now. Thank you. [Applause.]

Senator RIEGLE. Thank you very much for very powerful testimony.

The next witness is Doris Sieffert to be followed by Hodges Mason.

Doris, let us hear from you.

STATEMENT OF DORIS SIEFFERT

Ms. SEIFFERT. I thank you for coming to the State, and we're aware of your concern. The ability to get meaningful legislation here in the State of Michigan, I have totally given up on. In 1983, the county council of the City of Detroit passed a resolution, sent it to Governor Blanchard. Neither its sponsor nor its advocates have since heard one step that emerged from that resolution to consider the Ontario health insurance plan as a model to provide some start, some initiative from the governor's office to do something.

Recently or not so recently, probably around six to eight months ago Governor Blanchard—and I'm a Democrat, and I'm pretty sore with this man at this point—Governor Blanchard got so far that he finally acceded to form a task force on health care.

To my request to be told when it first met, if it met, what it did, I have had no response. Other critics have found that not one meeting has been held of that task force. So I believe that all this stuff is smoke screen stuff on the State level.

I wish it were not so but it is. And therefore, as influential as the Gray Panthers are, we have at the top of our agenda nationally, locally, wherever we are, wherever we go, a petition drive for the

national health service which is at the top of the Gray Panther agenda.

Any one in this room today who is not a member please see me and get aboard. We've got to work at this. It's not going to happen automatically, but I will tell you that petition signatures are pretty easy to get, and we've got blanks here.

George Pollak is in the back of the room. George, would you stand up, please. George Pollak has petitions, blank petitions to sign. Do something, people, instead of agonizing. Do something. We already have these signatures so easily. We continue every where we go.

Somebody said the other day, where Doris Sieffert goes so there the petitions go, and that's what I'm doing here. It's the only reason I'm here today. So please help me and do something.

Now, I want to give you some news. The momentum that's growing for a national health service is something that no 1988 candidate will be able to ignore. We'll see to it. All the people will see to it.

You see it here today. The momentum and the desire is there, but we will not, we will not, accept candidate's proposals which keep us in the claws of the profit making insurance companies. We will not believe what the American Pharmaceutical Society has done, the industry, excuse me, not the society. Scratch that.

On the back of the throwaway newspaper, Mature American—those of you know what I'm talking about see it in every senior center. That newspaper has been sold. The new owners provided ad space on the back page of Mature American for the American pharmaceutical industry. Their ad is an absolute travesty on truth.

By innuendo, out and out dishonesty, misinformation, disinformation, that ad is an alarm system to keep you off getting good catastrophic insurance legislation. When you read things like that, I want you to read the bottom. See who sponsored it.

Inside that newspaper what purports to be a news story echoes exactly what's in that ad. Now, it didn't go unnoticed. Not all of us can be duped, you know. If there's any industry people here you better know it.

The American Association of Retired Persons nationally published a newsletter. A day or two after I wrote a letter to the Mature American to find out why that ad was worded that way and dishonestly reported inside the pages of the newspaper, I got my AARP newsletter.

First page story, AARP indicts the pharmacists for doing this. They had picked it up nationally. They know what's going on. Now, that's not the only scam we're getting, and I want you to know that while some of the intentions are good, some of the legislation coming from your congressmen's office—not this Congressman, I'm talking about the Kennedys and the Waxmans and some of the other people. They're good but they're not modest. They're people who think we'll do this thing gradually. Let's sort of sneak up on it.

How many millions of people have to suffer as they sneak up on something that I am entitled to by rights of the Constitution and so are you? The National Senior Citizens Council, something like 4

million members, they've caught on. A few months ago in the newsletter started printing petitions for a national health system.

Look at these people. We know where it's at. I think the Congress with the possible exception of Senator Riegle and others are way behind the public. The public knows what it needs. The public cannot, without jobs, with part-time jobs and no benefits package, they cannot afford to get these drugs.

I have two early detection statements and then I'll quit. Once I get started, I don't know where to stop. But my two early detection statements——

Senator RIEGLE. I want to hear you but I also want to make sure we get a chance to hear the others.

Ms. SEIFFERT. That's right. I do too. But I want to catch people before they leave to get signatures on my petitions. Please don't go.

But there are two early detection statements ring bells in my head, and that is, repeatedly radio, television, newspapers, workshops, meetings, early detection. You've got to early detect cancer. If you have any hope of living with that for awhile, and they can keep you alive for a long time, but early detection is the key.

Now, you're deciding whether you pay the rent, whether you buy food at the supermarket or you go to the doctors and you're not hurting, you see, this is the early detection stage. Nothing is bothering you. You're not going to go for that vital exam. If you don't find out about that lump—I don't care whether it's in your leg or your breast—if you don't find out about it in good time, the poor are going to die much more often from cancer. It's the agonizing indifference of society that a person didn't have early detection.

The other early detection story and then I'll finish. Early detection is knowing when you got a problem. We have problems in this country, and it's how to get preventive and good health care for everybody, whatever age.

We have a problem and we are the only country besides South Africa among western industrialized nations in not having a national health service. What do they do with our defense money? They blow it up. They get the system going and subcontract out a lot of these so-called defense things, and then they scrap them. That's your money going down the tubes while you're waiting for early detection.

You don't go for early detection, most of you in here, most of your friends. They might be alive today if they had. Now, early detection is we have early on detection for serious problems. We have early on dete[illegible] and there is a way to deal with it, and we can't on with a little scrap here and little scrap there.

Please wait. Please sign our petitions. Let's get moving. Everybody else is.

Senator RIEGLE. Thank you.

Mr. Mason, you've been very patient. Let's hear from you now, and then you'll be followed by Mr. Gordon Andrews.

STATEMENT OF HODGES E. MASON

Mr. MASON. Thank you very much, Mr. Chairman. My name is Hodges E. Mason. I am the president of the California Community Council and former president of Local 218, UAW. I am a 61-year

resident of the city of Detroit. I have made my contribution. I have been working in this town for more than 60 years and I helped to build it, and I don't like what I've seen.

I would first like to commend you, Senator, for holding this hearing. I think it is something that had to be done. I'd like to further say that in order to treat a condition a doctor has diagnosed it, and I think that's what we should do is quickly diagnosed for whatever the trouble is we have now.

Health care is no longer for the people but for money. When you go to a hospital and you can have Medicare right now—I am very sorry that the representative of Mount Carmel Hospital is not still present, because I know what transpires there. I had it happen to me.

I am very very glad to see some of the old union men around here. And it happened that in 1939 a lot of those guys went out on strike, a lot of bus drivers went out on strike, and one of the main demands that we had was to have them deduct, the union, deduct dues for the Blue Cross and Blue Shield.

They sent a fellow in here by the name of Mike Kamm in 1939 saying that they were in New York but they were not coming to the labor capital of the world. Our local was the first one that subscribed to it.

They said it was the forerunner of nationalized medicine, and they pointed out that the doctors were all on starvation wages which was true, and they said that they would get better health care if you subscribed to Blue Cross.

When the Medicare program was introduced, and I'm sure you know what they did, the Blue Cross and Blue Shield spent $500,000 to defeat the Medicare program, and they have sold the people completely out.

I was taken into Mount Carmel Hospital nine years ago in a very bad state. They had to break into the house and get me out of the bath tub. Mount Carmel Hospital held me out of there even though I was sick enough to be in there for three days and two nights without admitting me. They kept me in the head person's room. I don't know what it is. I was kept there without even food.

They came to me and apologized for it saying that they were wrong but I could have died. The only reason that I was admitted was that they saw that a lawsuit was imminent.

The point that I'm raising is, when you go to a hospital today, they don't diagnose your case. What they do is they get how much insurance do you have, where is your money, we can't take you unless you have it. [Applause.]

I want to tell you this right now that there are those who say that these things don't happen. They don't have it, a lot of them, because of the fact that the health care programs will drop them.

I think I gave you a complaint that I registered against the medical insurance. I have been in it with them for a little over 2 years now, have never been delinquent in a payment, and I received a communication, a copy of which you have, informing me that I am being dropped from that health care plan as of January 1.

I appealed it to the insurance commissioner, and I think that they will renew it. They make thousands of dollars off of thousands of people who do not have claims against them and never have. It

happens that I have some claims, but it isn't a matter of who can pay more money. It's a matter of when you pay into it according to the law you are not supposed to be dropped.

I paid the 4 months due. They told me that I paid one. I paid four anyway because I appealed.

Now, I think that what you should do in this field is demand that the cities and the councils will provide hospitals for the poor, the things they used to do. The City of Detroit closed the receiving hospital, turned it over to the medical center, and to be frank about it, we paid for it.

And a person doesn't have a place to go now to die in dignity. It's a shame of us all. They couldn't go to Washington to ask for money to keep the hospital open so that the poor people would have a place to go to be treated or to die in dignity, but they can put on a campaign to take care of the chimpanzees in the zoo. It is a shame before God. [Applause.]

Now, as far as I'm concerned, sir, I want you to understand thoroughly that when this bill is introduced, it should be stipulated in there for that $4 a month that they must not kick people out because of the fact that they have complaints to register.

The other thing is that Blue Cross has come in and put these doctors and these hospitals over the people that are paying, and Blue Cross rates go up everyday. They are outrageous, and they cut this off and that off and the other thing. The UAW made Blue Cross.

So there will be no misunderstanding about it. Right now I'm for it, but at least put it there when we were out on strike demanding that they take out the Blue Cross. We have gone through this.

I have 62 years of my life in this town trying to help to build it, and there are a number of folks out here that know better, and I'm sure you know it. I have put practically all of my life into it, and here I am victimized because I have to go to the hospital for surgery twice. I am being kicked out of the health care plan because of a complaint. Why are they in the business if they're not going to protect the people that are in there?

What I'm pointing out is a lot of these catastrophic cases could be permitted if the insurance commission would make the health care plans take care of their people instead of dropping them.

They send the letter just arbitrarily and tell them that they have no such coverage, and they have no regress. We are in a position that we need your help and I urge you to, please, include these things in that proposal, because of the fact that the people are suffering.

Right now a person who has cancer can't even get an ambulance unless he pays over $100, and he has to pay $600 a day to go into a hospital that was supposed to have been for the poor people, and they will not take you once you go in there if you don't have that $600.

I'm sure that there are people present that realize that everything that I'm saying is true, and I urge you, please, see if you can't do something about it. People are talking about it right now. People have been paying $10 a month for a health plan, and they jumped it up to $55. It is ridiculous. We are suffering, and we need your help.

And I've got to again thank you for having been so kind as to hold this hearing so that you may understand thoroughly just what the story is. We need this health care program and we urge you to continue to fight for it along with Senator Levin. Thank you.

Senator RIEGLE. Thank you very much.

I'm going to read down through the names here so that we know who is coming in order here, and then I'm very concerned that we're not going to have enough time to get through everybody unless we move along a little quicker.

Let me go through the names. Our next speaker is Gordon Andrews. Let me just read the next ten names so people can be ready. Coreen Jones will follow. Mr. James Berry, Rosie Jones, Lila Hatton, Ms. Mary Rogers, Corliss Ford, George Moore, Willa McKinney.

Gordon.

STATEMENT OF GORDON ANDREWS

Mr. ANDREWS. Thank you, Senator.

I'm sorry that more of our brethren couldn't remain, but I myself understand that precisely. I had the privilege and the pleasure of attending Senator Riegle's forum such as this not long ago, and he had in attendance approximately 600 people.

My question is how many today did your staff count before they began to leave. I have a reason for this.

Senator RIEGLE. We've had about 400 people here today and some have come and gone.

Mr. ANDREWS. Good. You had 600 before.

I believe that in the hearings you are holding, the truth that will be borne through these will be felt by our elders for generations to come. The groups I'm associated with I am not going to read them all. It's like a litany of the saints. We're here to do a job.

I have come to question and to thank you. In the words of a psalm Mr. Walter Reuther quoted, calling upon the God of creation caste me out when I am old. Walter Reuther took that right out of God's holy word.

You, sir, are in modern times doing the same thing. You are getting down to where we live, and I applaud you for it. First of all, to the nitty gritty and then I'm through. Quite some years ago, I was told, as well as many of my colleagues, at a convention of the national senior folks by a young lady from the State of Ohio who at that time, I believe, was a U.S. Representative and is now a Congress person, and 5,000 of us in round figures were down there, and I heard from others of your peers that Social Security must come out of that budget picture.

It should be separate and apartisan as it was in the beginning, and any President or would-be President who wants to play games with the moneys for we old folks will find the God of justice before him.

Second, sir, on this defense budget, against whom are we defending ourselves? The difference in the amount, and if you or your staff happen to have the figures at hand, what are we paying out, we the people are paying out for alleged defense that the Russians are coming.

Well, they're looking over their gates to see if we're coming. We're close to half way there now. We're in the gulf, and what does this government spend on folks in old age? Compared to those figures, where are our priorities?

People like you, Senator, and a few others are going to have to do some missionary work down there upon your colleagues because, and I emphasize this, years back the Russian peasants stood outside the walled gates and watched the aristocracy dying in sinful wastefulness.

Their payment date came. The people in this room and across this land are going to demand a day for counting. With that, sir, for myself, my colleagues with the trade union movement, we thank you.

Senator RIEGLE. Thank you for your comments and strength.

Coreen Jones.

[No response.]

James Berry is he here?

[No response.]

Rosie Jones.

[No response.]

Lila Hatton.

[No response.]

Mary Rogers.

[No response.]

Corliss Ford.

STATEMENT OF CORLISS FORD

Ms. FORD. Thank you, Senator Riegle, for allowing me to speak at this time. I'm concerned about the rapid growth of my health care. That affects everybody. I'm a sick woman living on a fixed income and Social Security and have Medicare and also have help.

I have a letter here from the health carrier for January of 1988 that my health insurance which is $48 a month is going to go up to $55 a month, and my $2 co-pay for insurance is going to $5, not $4, up to $5. I looked it up this morning to see—they don't let you have a bill. I had it since 1985, in November, and I've paid every year. They are cancelling some people who have paid all this time.

So I'm concerned about the cost of health coverage. I can't afford it. I don't know what I'll do if I can't pay. I'm paying about $80. I can't afford that every month. I hope you can do something for us.

Senator RIEGLE. Well, I appreciate what you have said. I think you have illustrated the problem very well. I have an office in Detroit in the McNamara Building on the 18th floor. Anytime anybody has any problem that you think we can help with, whether it's going through these cost increases and helping you understand them, finding out if there's some way around them or if there's some other answer to it, you should come down to that office or call on the phone. I'm not just talking about today, but day in and day out or next week or next month. The office is there to help anyone with problems that arise with Social Security and other Federal Agencies.

I want you to come. We help people every day. So if somebody has an individual problem of some kind that they need help with, you ought to come in and see us.

Ms. FORD. Thank you very much. My desire is to get a hearing aid, and that's not covered here.

Senator RIEGLE. I am going to call on Nancy Asbill. I know you're here with your son. You will be followed by George Moore, Willa McKinney, Theodore Engram and then Mr. Vernon.

STATEMENT OF NANCY ASBILL

Ms. ASBILL. Thank you, Senator. I am not used to speaking in microphones. In fact, they make me nervous, but I'm going to try. My son was hit by lightning 9 years ago.

Senator RIEGLE. I want to make sure everybody can hear you. She started out by saying that her son was hit by lightning 9 years ago and her son is up in the back in a wheelchair.

Ms. ASBILL. Right. He's considered postsecondary, and he was at home for a long time. He, at first, was taken real good care of, but now even though my husband is working, they said if we bring him to school, he's going to be in eighth grade reading and multiplying. They gave us all kinds of complications in the closed setting.

Now, he was ready to go to school before the school was ready for him. They could not handle him. He's a little hyper. I can't sit right. You have to really restrain him down there. But I am finding that physical therapy is right in school. He can't sit too long.

But my concern is—he was hurt at 15. He is 23 now, and I'm glad to take care of him. But what makes me mad is I cannot get—there's all kinds of places around for help that he needs, but when I call them for the help, they say do you handle it for him; and I'll say, no, I have Blue Cross and Medicaid; and they will say sorry.

Today he wanted to put his coat on. He is slow, but he needs to get help to reach his maximum potential, and I can't get it for him. Now, his doctor who is the best in Michigan, my parents before me and all our seven children have all gone to him, and I don't want to leave the State, but I understand California can give him what he needs. There is a 6 month residency there, and I don't want to leave Michigan. I know people that have.

I don't know what their source is, but I know a family that has left, resided there 6 months, and got help for two girls who were in an automobile accident or some accident. But we don't have that in Michigan, and I can't give him the help.

He's really slow starting. It is just really hard to get the teachers who are trained for this problem. I have a person who is an expert, who was willing to help with a management arrangement, and they didn't want to use him because they know him. I've been no help because of his needs, but he needs to be trained so I would like to see someone help him fix a drink so he can learn it and take care of himself or at least try.

I'm not exaggerating when I say I know some other people that are worse. I can't complain because my husband will be working for two more years and I'm looking forward to the future, and we don't know what to do either.

But I know he can help himself if he keeps learning. He'll probably never need help again. He was an honor roll student, straight A's in school.

Senator RIEGLE. First of all, I want to comment about this because I feel very emotional about it. First of all, I admire your love of your son. I know how hard it is to cope with a problem like this.

We'd like to try to help you, and someone on my staff will be talking with you to see if we can't find a way to get the kind of help you need here in the State of Michigan. You shouldn't have to move to California or anywhere else to get the help you need. You should be able to get it here. So we want to try to help.

This reminds me of the story of the young man on our first panel. In a sense, getting struck by lightning is probably the ultimate act of chance. Who gets hit by lightning? If your son did, any of us could, any of our children could.

I think it focuses very directly the question of whether we care about each other, whether we want to have a society where we really care about what happens to the person next door, in the next block, across town and in the next town.

I think in recent years we've gotten away from that question. The example that we've been getting a lot from the higher ups in our society has been if you just look out for yourself, just go and get what you can get and as much of it as you can, that that somehow serves the public good. That's too narrow a notion, and it doesn't do enough to meet the public good, because we've got too many problems out in our society that we need to meet head on if we're going to have the kind of society that I think we ought to have, a humane society, a decent society.

I think we have gotten into the habit of looking away from problems like yours which could be our own problem today or tomorrow or the next day, and it's not right. Somehow we've got to, I think, examine our conscience as a Nation and look at our values and decide what is really important, because we spend a lot of money on a lot of things that don't have anything to do with helping people who desperately need help who are right here in our own community.

We have seen a lot of focus on so-called national heros in the last few years, and some of the people that are called national heros I don't think are national heros. I think you are one, and I do think other people that are in situations like yours that are struggling day in and day out to help somebody they love are the heros.

Ms. ASBILL. I think there are many out there.

Senator RIEGLE. Well, there are, but you come today and represent all of them, and so let us see what we can do to help you. I admire your strength and your courage. Thank you.

Is George Moore here? Willa McKinney. Theodore Engram.

STATEMENT OF WILLA McKINNEY

Ms. MCKINNEY. I don't want to do repetition of the people that have no insurance because that's been covered. That was one of my points. But I would like to speak about car insurance for people who do not have it or are underinsured or uninsured.

You never know when somebody hits you. I'm not a driver. I was a passenger. But I'm the one in that situation, and it hurts when it hits you.

I'm also an ex-State employee in which I worked 12 years for the State, and I worked many jobs, of which I worked two jobs, and sometimes after working a double shift I worked on my off days, and I was never paid $7 an hour.

Therefore, the insurance that I need I cannot afford now with my disability. I have just enough money to be ineligible for Medicaid. I have approximately $95 of medical expenses every month for which I have to cut funds and decide what medicines do I take, what medicines do I let go.

And these are things that are very important. There needs to be something for people that fall into this Catch-22 like myself. I have been my own doctor, my own nurse, and my own therapist. I am a manic depressive of which this was my initial reason for stopping working. It's very hard for me to stay out of the hospital without having mental disease.

This is something that I have to do the priorities, and when it comes to paying and things like that, I have to do without medication because I can't afford medications. I go to the swimming pool every day except Sunday at the Williams recreation center at which I exercise my legs.

I find many things that I have to do that my personality says no. So I see Dr. Richy and the people at Wayne State University and their response is very nice. They have helped me a lot. I have found myself in the mayor's office because I needed transportation and I couldn't find transportation.

So these are things that you don't think about. It's been 15 months since I have been in this position. I have been working to where I am working with other people that are in the situation that I'm in, and I have used some of my training that I have had under the State in forming our own support group, and I will say to the people, please, if you know anyone that needs your help, don't turn your backs on them. Help them, because you don't know when you may be the person that needs that help.

Thank you.

Senator RIEGLE. Thank you very much, Willa.

Is Theodore Engram here? We would be pleased to hear from you.

Is Mr. Vernon here or David Sole?

[No response.]

In any event, Theodore, let's hear from you.

STATEMENT OF THEODORE ENGRAM

Mr. ENGRAM. Yes; Senator, I am glad to have the opportunity to get up and speak just for a few words. I would like to know how I would get into helping people in home where they are having problems there, a stroke or something like that. My wife, she fell down in this room. I didn't know what to do. I was running back and forth to the telephone. In a few minutes, she comes to. What happened? I said I don't know.

But I think anybody in the home needs to know something about this.

Senator RIEGLE. I agree with you. So you're asking the question how do you go about getting some training to help other people understand that this could happen to them?

Mr. ENGRAM. Yes; back in my home now because I can't go out.

Senator RIEGLE. Well, I don't know the answer right off the top of my head, but let me check and see how you might do that.

I am told by the audience here that the people at the American Red Cross apparently have a program for that very purpose. I assume that means that they meet periodically and they explain exactly what to do when certain things happen in the home.

Apparently the American Red Cross has a program like that right here. So you should call them and find out when their next meeting is going to take place, and then go to that meeting.

Once you've gotten that information, you may be able to participate yourself in their programs to teach others.

Mr. ENGRAM. Thank you.

Senator RIEGLE. Thank you for coming.

Is Nancy Griffith here? Sandra Gillmore? Cy Ford?

[No response.]

Senator RIEGLE. A lot of these people I know sent us notes to the effect that others who have spoken have already made their points so that they did not wish to speak.

Paul Bridgewater.

STATEMENT OF PAUL BRIDGEWATER, EXECUTIVE DIRECTOR, DETROIT AREA AGENCY ON AGING

Mr. BRIDGEWATER. Good afternoon. I am Paul Bridgewater, executive director of the Detroit Area Agency on Aging.

The Detroit Area Agency on Aging constantly strives to meet the diverse needs of older people by linking them to services which assure their independence. As a single-purpose, non-profit agency, it serves over 224,000 older adults residing in Detroit, the Grosse Pointes, Hamtramck, Harper Woods and Highland Park (Planning and Service Area 1-A.)

Founded in 1980, DAAA fulfills the mandates of the Older Americans Act of 1965 (as amended) by taking on a planning, advocacy and comprehensive network of services for the elderly which enhances their quality of life.

As a planning agency, DAAA is at the forefront of initiating new and creative ways of addressing the many needs of older persons. It carefully plans services by conducting research to identify problems and gaps in services. The agency also obtains input from the community in order to provide the best possible range of services with its limited resources.

As an advocate for older people, the DAAA works with organizations, professionals and seniors to address a variety of issues affecting the aged. The agency also acts as a catalyst for the maintenance, expansion or creation of services.

As an administrator of Federal and State funding, the DAAA strongly encourages the coordination of services. These coordination efforts seek to leverage funding, minimize duplication of serv-

ices and encourage the maximum use of resources for older adult services.

The Detroit Area Agency on Aging's position regarding catastrophic health care is in concert with the position recently adopted by the Area Agencies on Aging Association of Michigan and our comments here reflect that agreement.

We are concerned that both the House and Senate proposals fail to address the most pressing health care need of the elderly—that of long-term care services, such as home health care and nursing home care. An elderly person is; much more likely to need long-term care than extended hospitalization benefits, which are the primary addition offered by the catastrophic proposals currently under discussion. We urge Congress to lend its intelligence and consideration to the long-term care issues after the catastrophic care proposal has been resolved.

There are several new benefits under discussion that we support. We support the prescription drug benefits offered in H.R. 2470. The benefit, which pays 80 percent of drug costs after a $500 deductible, is one of the most valuable aspects of the bill and will help many who are facing astronomical bills for prescription medications.

Senator RIEGLE. If you'll just let me interrupt, I don't think we ought to elect a President that doesn't have a program in this area. I think we should demand that of the candidates. If they can't come up with an idea, then they're looking for the wrong job.

Mr. BRIDGEWATER. Just to give you a figure, research shows that for over 75 percent of the elderly, the cost of prescription drugs is their largest out-of-pocket health care expense. Older adults use three times more prescription drugs than other age groups and account for 30 percent of all drug expenditures, even though they comprise only 12 percent of the total population which shows that there is great need for some program on prescriptions.

We support the spousal impoverishment benefit included in H.R. 2470. This benefit would require States to allow spouses of Medicaid nursing home patients to keep at least $925 in monthly income and $12,000 in liquid assets. This would enable the spouse to continue living independently in the community even though her husband is receiving nursing home benefits through Medicaid. Not only is this benefit more generous than the benefit currently offered in Michigan, it establishes a national minimum standard for all States to follow.

We also support the new respite care benefit included in the House proposal. Although a modest benefit at 80 hours per year, it is a significant first step in assisting care givers who play a crucial role in providing long-term care to elderly family members. It has been established that family members and friends provide 80 percent of home care that elderly people receive.

The modest increases in home health care and nursing home benefits are welcome, even though they do not adequately address the need for long-term care. We support the elimination of the three-day prior hospitalization requirement and the reduction in the co-pays for skilled nursing care.

Senator RIEGLE. If you'd yield to me one more time. I'm very proud of that because I offered the amendment to correct that and

it carried in the Finance Committee. So that was one area that we had a chance to bring the hammer down and get some thing done.

Mr. BRIDGEWATER. Yes; we appreciate that. I was in Washington this summer and just a couple of weeks ago, and I am very proud of our Michigan delegation is dealing with these catastrophic health care issues. We certainly appreciate that. [Applause.]

The abolition of the difficult "intermittent care" standard for home health care is an improvement, as is the expansion of the number of days covered.

We have concerns about the financing mechanism included in both the House and Senate proposals, however. The elderly could pay part of the costs of these enhancements though an increase in the Part B premium. But both bills rely solely on increase in the Part B premium to finance the Medicare improvements. We believe that the entire cost of the catastrophic care proposal should not be borne by the elderly themselves. That financing mechanism would be counter to the basic principle of all insurance, that is, to spread the risk over the entire group of potential beneficiaries, making the coverage affordable for all. Every working citizen in this Nation is a potential beneficiary of the Medicare program and should also accept some financial responsibility for these benefit improvements through FICA tax increases. This would lessen increases in the Part B premium, which is now so high that some elderly forego Part B coverage now because they cannot afford it.

While there is some evidence that DRGs have helped to slow the growth in hospital costs under Medicare, we are concerned about the lack of a cost control mechanism for outpatient care, physician services, laboratory services and prescription drugs. In fact, consistent increases in physician charges is one of the reasons that the Part B premium is scheduled to rise by 38 percent next year. Price increases in prescription drugs are the largest in the health sector and, in the absence of cost control mechanism, will create significant problems if a prescription drug benefit is added to Medicare.

Mr. BRIDGEWATER. A number of people have talked about the cost of drugs. Just to give you a figure, research shows that over 75 percent of the elderly has cause for prescription drugs as part of their health care service. Older people use more than three times more prescription drugs than any other age group and accounts for 36 percent of all the drugs prescribed even though it counts for only 12 percent of the population, which shows that there is a great need for some program with respect to prescription drugs.

We certainly support the powers in Congress to mold a bill for health care and drugs.

Thank you for coming here.

Senator RIEGLE. Thank you. Before you leave, let me say something to you and to others that are trying to help other people. You could be doing a lot of things with your time and money. You wouldn't necessarily have to spend it the way you are in this leadership capacity. I want to tell you how much I appreciate your efforts and I know everybody here does, for the work you do and the number of lives you touch.

We need more examples like that. We need more people who are willing to spend their lives helping other people, not just helping

themselves, and you're a giant in that respect. I admire that very, very much. [Applause.]

Mr. Albert Hentz. And then let me read off a few names to follow. Mary Jane Lyle. Is she here? She is gone. Emma Douglas. She is gone. Nina Weiss. Diane Daley. She is here. Beverly Blowdell. Annie Moore. Dr. Michael Kuppernick. He is not here. Genora Thompson-Long. Thia Gowyang.

Albert, we'd be pleased to here from you and thank you for coming.

STATEMENT OF ALBERT HENTZ

Mr. HENTZ. Thank you, Senator Riegle. I admire this meeting that you're holding in the City of Detroit for all the people of the city, and I only have a few words to say. I am a retired citizen from the Ford Motor Company. I worked practically all my life in this country alone, and I'm quite sure more people my age put much money into Social Security.

In fact, I would say I helped build up America from work yesterday, but I'd say in the last 9 years it seems like what we have worked so hard for, your father and brothers and sisters, worked so hard to gain, it seems like the last 8 or 9 years that has not come to us.

We don't have no money for health care. The State has no money. The city has no money. But the people with the large mortgages, where did that money came from? There's a question there. How did all the money get to those people?

And so many people out there are starving. We got people in the hospitals. We got people being cared for in the hospitals and sent back home. I visited my friends in hospitals twice, once this week and once last week. In fact, he's in there now. His wife takes him to the hospital three times last week. They kept him only about 12 hours and sent him home without treating him. They had to call and come back and get him.

Senator Riegle, this man is no better than any other man. He is a World War II veteran. He retired from an automotive company. And what I'm saying, where did the money go that he helped put up for his protection and other people's protection under Medicare? Where did the money go for that protection?

And it's heartbreaking. I have been voting for you ever since you ran on the Democrat ticket, and I will be around to vote, and I admire your work. I've followed you quite a bit in the paper and the radio. I love the radio and the paper. A lot of people like to look at it, but I like to say what they're saying.

And I like your work that you do, but I know you can't do it by yourself. But I hope and pray that you hear the support you have around the State of Michigan and that when you get back to the Senate floor, it will have plenty of weight with you to help assure us people in Michigan and in the United States. Thank you. [Applause.]

Senator RIEGLE. Thank you very much. Those are very gracious personal comments, and I appreciate them. You ask profound questions and important questions in terms of where we are as a country right now and how did we get here.

Well, it doesn't have to be this way, and we can work our way out of these problems. We can't just surrender to bad conditions. We can't just throw up our hands and say, here we are and we can't do anything about it.

Now, there are some people that would like to see that happen. I'm talking about the people that are well situated, those who wish that everybody else that had a problem would just sort of go away and not bother them.

But the rank and file people that built this country, and you're one of them, and you mentioned the ranks of people that have done it and fought the wars and all the rest of it, are what this country is really all about, not a handful of big shooters.

We can have the kind of future we want for ourselves. We've got to pay attention, and we've got to get organized and we have to register. We have to vote. We have to run the campaigns. We have to circulate petitions and do a lot of things that were talked about here today and get an organized effort going.

So in a sense, we're going to write the story ourselves. If we care enough and want to get organized in a serious way and put this country on a different track, we'll put it on a different track because there's strength in numbers.

There's one thing that rank and file people have and that's numbers. Now, we can get led off down the side road, and that's happened before for different reasons. But if people take a look at things and I say I don't want to go down that road any more; I want to go down a different road to a different kind of a future with a different kind of a set of arrangements and commitments then we can solve these problems, because we're a very wealthy country.

Now, we've wasted a lot of money, too. Over the last few years, we've run up huge deficits. A lot of it's been wasted, frankly, in military spending. We've seen a lot of examples of that. As you know, a lot of other countries around the world take a free ride because they figure as long as we're willing to pay the bills, all is well and good. They'll let us pay the bills and they'll take the free ride.

Well, we can't keep doing that. We don't have the money to do that. It's not smart anyway. Even if we could afford to do it, we shouldn't. And we've squandered the money in certain other ways.

We're also going to have to organize ourselves, to work harder, and we all work hard. But I know I'm going to have to work harder, and I think that's true for everybody else. We shouldn't kid ourselves about that. All of us are going to have to figure out how to become more productive, produce more, work harder, and do a better job, and I start with myself. Certainly that's going to have to be true of the next President as well.

That's part of getting ourselves out of this situation, too. But there are ways to deal with this problem, and we should not just throw up our hands and say we are overwhelmed. I don't buy that. We don't have to be overwhelmed.

This country belongs to the people, and a democracy gives us the right, in fact, the responsibility, to decide where we want to go and how we want to get here. So we don't have to accept some future

that we don't want. We can have just the kind of future we want if we're willing to fight to get it and work hard to get it.

Diane Daley.

STATEMENT OF DIANE DALEY, GERIATRIC SOCIAL WORKER, CATHOLIC SOCIAL SERVICES

Ms. DALEY. Thank you, Senator Riegle, for providing this hearing today. I am a geriatric social worker in the Catholic Social Services, and I am involved with an outreach home for seniors who are sick and their families.

I come today because I am concerned about all levels of health care but especially about the mental and emotional fear of our senior citizens and their families. I get very emotional because I work a 5-day week, and I'm on call on weekends, and I am touched and overwhelmed by the types of depression that I see, and a lot of it is not really serious depression. I'm talking about statements from society that say you don't really care about me when I grow older.

We're talking about people who have lost. We have people here today saying I don't know this country and who are we to be treated this way. I hear this all the time. In fact, many of my clients say to me Diane, don't grow old. This is astonishing to me.

The depression that I'm seeing is something that I wish everybody could see. Sometimes the depression is so severe they want to kill themselves.

When our Government does not have a national health care policy and we don't provide enough outreach counseling—and I want to let you know that we're funded by the United Way agencies for the services that I provide, and when I provide services, I am the only worker for about 25 patients that extends from Detroit's west side to western Wayne County.

I cannot take all the calls they're giving me. We are not reimbursed through Blue Cross or any other health insurance or Medicare for outreach counseling, and I'm talking about people that want me to come to their homes since they cannot come to me. The stress on families is unbelievable.

We need more care from the social services for outreach counseling, and hate management. We need to bring individuals up for services in their home to protect them from further depression and isolation and loneliness.

I want to tell you that if we don't get additional services which I'm talking about transportation, affordable home health care, home and support services. The funds run out. This is a social problem.

In fact, these seniors helped build this country. This says you're not worth anything. I can't tell you how many times they say it.

But this is a strong image. It is also thanks for our giving people. I have one 10-year-old girl who is pretty sharp. She happened to overhear a conversation as we talked about not enough financial contributions to our senior citizens, not providing effective programs to meet their needs.

This 10-year-old girls said, gee, I don't understand that. We're all going to grow old some day. This is just another reenforcement

that you've grown old and you don't count. And I want to tell you, let's take a look at what causes this today.

I want to tell you just two quick little stories. I was asked to go visit with a client and if I couldn't go right away it would be too late. This person I went to visit was bordering on suicide, and he thanked me for at least coming there.

I would also like to speak about providing outreach services. Outreach services doesn't really bring any money in so a lot of places won't do that and that's why Blue Cross won't pay for it.

Another situation was an elderly gentleman and his wife. He had been placed in a nursing home because his wife would not care for him. She had a mastectomy. The family was very distraught. They were all confused about assistance. It didn't worked out between the families, and I was called in to provide services.

The gentleman is now in a nursing home, and I do on-going to therapy with his wife, and I go to the home practically on a weekly basis. This woman is now 71-years-old, has a loss of health and lost a breast because she had mastectomy. She doesn't have her husband, and now she has gross financial insecurity.

Before, she received approximately $217 a month. This is what happens, and I implore you, and I know, Senator Riegle, you are an advocate for these kinds of services. But I think we as a society really must look at this, and what scares me is could really take care of them by ignoring the problem, and I'll tell you that I don't think that's a very good way to face it.

I believe the present administration is closing their eyes, and anyone who supports them are also voting against themselves. So I think we better look at what our morals are and what we're teaching our children and look at the message this sends to our youth and our older people.

Dr. Vincent, I agree with whom, said, you measure the country on how it treats its young and its old, and I am not real pleased with what I see, but I congratulate you for trying to bring the issue to our national attention. Thank you. [Applause.]

Senator RIEGLE. Thank you. And let me thank you for your personal commitment for what you do, because I am very touched by the fact that you are spending your time and energy that way. If there are other people here who have the capacity to help other people who are really caught in impossible circumstances and if you're in a position to help do some counseling, there is a way for you to get hooked up with that, do it.

I urge you to think about it because we need more people doing it.

Ms. DALEY. And we need more money to fund it.

Senator RIEGLE. Absolutely. Thank you for coming.

Is Loretta McNamara here? T. James Paige. Melinda Callaghan. Mr. Paige, you're going to speak for Melinda. Let me just go through a few more names here so they'll know who follows.

Is Dorothy Miles still here? Gerald Yettaw. Rita Gullette. Ernest Strauter. Gertrude Cook. Marie Sarrass. John Sefcik. Nina West. Dolores Howell. Kenta Nation. Kate Woods. Doris Williams. It looks like Hewlett Benjamin Franklin. Kratin Rippey. Charles Ford. Rabbi Markham and Nona Gray. Evelyn Allen. Pitt Wilkin-

son. Dr. Dave Williams, Senior. Mrs. Dorothea Jackson. Mel White. Sandra Kent. Theotis Matlock. Reverend Carruthers.

Very good.

Mr. Paige, we'd be glad to hear from you.

STATEMENT OF T. JAMES PAIGE

Mr. PAIGE. Senator Riegle, we are pleased to have you in our city on an important and most-needed issue. Most of my questions have been answered, but I would like to say one thing. The only way the problem can be solved, first we have to recognize that there is a problem, and then it can be solved by working together, all of the people.

I, for one, am very pleased with the work that you have done down through the years. I have followed you ever since you were in office and even before that. But one thing I would like to ask is there a possibility of getting a transcript of this meeting.

Senator RIEGLE. Yes, in fact, we're taking the whole thing down. That's what this woman over here is doing, making sure we have a full transcript, and anyone who wants a copy will have one.

Mr. PAIGE. Thank you.

Senator RIEGLE. Thank you for coming.

Melinda Callaghan? You're going to speak for her?

STATEMENT OF DON LOWSON, REHABILITATION INSTITUTE OF DETROIT

Mr. LOWSON. My name is Don Lowson. I am the director of the Center for Independent Living at the Rehabilitation Center.

Senator RIEGLE. Let me say one thing. We have about nine more people to go, and we've got to move out of the auditorium in a half an hour. We have a half an hour, and I want to divide the time equally. So I'm going to ask everybody to hold their comments to about 3 minutes, if they would, so that nobody gets squeezed out.

Mr. LOWSON. My comments will be brief. First of all, I welcome you, Senator Riegle. I am representing the Rehabilitation Institute of Detroit. 175 rehabilitation houses are located in the Detroit Medical Center. We are a health care provider for hundreds of Medicare and Medicaid recipient per year, people who have strokes, are amputees, and who have sexual diseases, MS.

Through a survey done of disabled Americans conducted in March 1986 in cooperation with the National Council on the Handicapped, they commented, and I quote:

> A discouraging rate of poverty among elderly disabled persons, one-third of all disabled persons age 65 and over reported household income of $7,500 a year or less. Six out of ten elderly disabled persons reported household income of $15,000 or less.

The Rehabilitation Institute encourages you to include reimbursements for the following services as part of the catastrophic health care protection program—that long-term care costs be covered; that surgical medical equipment to increase independence through a system of devices be covered; that there be provided reimbursement for home-bound therapists thus reducing long-term costs; and to provide education for victims of catastrophic illness.

We at the institute have made great strides in reducing costs through efficient services; however, facing the current structure of

Medicare, we are unable to provide the full spectrum of services that must be ever present to serve this population.

Let me personally say as the director of the Center for Independent Living I am proud and like to give hope to people who have to face the issue of catastrophic illness and the problems. With me today I have four individuals who are in my program. It is the only residential program of its kind in the State of Michigan, one of 13 across the country, and I am very proud of it.

We provide services to teach people how to be independent, to live and manage their own affairs with dignity. May I make a political statement and say we teach our people how to be real advocates in spite of their disability.

Just 2 weeks ago, the young lady you had mentioned, Nina McNamara, got a microphone from Vice President Bush when he was here in Dearborn. She, through her training in our program, has acquired a lot of information about transportation and the problems of transportation for the disabled.

She confronted the Vice President and asked, sir, since you are running for the President of the United States, what will you do for us? That is a second hope that we can offer as a rehabilitation program and as a service.

I know we talk about a lot of negative things here, but we ask you to support, as I know you have, all the same issues. Help us continue to fund the network of CIL's across the country, and as a political voice, we will be there for you and for those who support us. I thank you.

Senator RIEGLE. Thank you. Are any of the four people still in the audience that came today with you or are they all gone?

Mr. LOWSON. No, we had to get them back.

Senator RIEGLE. Thank you for coming.

Gerald Yettaw.

STATEMENT OF GERALD YETTAW

Mr. YETTAW. My name is Gerald Yettaw, and I am from Local 157. I am also a patient. I've been to four hospitals for piggyback locations. I had a catastrophic illness in a sense. I was born with cystic fibrosis. I had great problems at age 5. At 9½, I caught scarlet fever. At age 13, I fell and broke my leg in three places from a three-story building. At age 17, I went in the Army. For 24 years I stayed in the Army, in the Army or National Guard. At age 47 I was diagnosed with a kidney problem. For 4 years I was on a kidney machine. At age 65, I had a kidney transplant.

The thing I want to talk about mostly, Senator, is medication for the kidney transplant patients. Cyclo sporine is an immuno-repressive. It is an extremely wonderful drug. The only thing is you have to wonder where you're going to get the money to pay for it.

It costs you $156 a week for the medication. If you don't have insurance, no insurance company is willing to insure it with the copay and everything like that. I unfortunately had an insurance I located myself, and they asked me to go to my credit union to negotiate an insurance for the people and I did.

What I want to talk about are catastrophic illnesses. Senator Riegle, I had a kidney transplant. I had a pacemaker. I had a

hernia that's been operated on three times and a broken leg again. I had cataracts in my eye. Social Security had a hearing on me. They said as long as you can stand, sit, and walk you can work. I said it's impossible, I told the man, I said, I can do your job. He said can you wash dishes, can you do this? I said I can do your job. He said you can get a job washing dishes, sweeping floors.

I said I can't live on $675 a month now. How am I going to do it on $3.55 an hour, Reagan's minimum.

Anyhow, Senator, I appreciate you and your whole staff, particularly Pat, for working with me and getting me my Social Security. I got that the other day. I have been working for this for a year and a half. When you're a transplant patient, you're supposed to get 3 years before you go back to work. I was a year to the day they sent me a letter saying I couldn't have Social Security any more.

I went into the hearing. They did nothing for me. They just took me out of the system. I was in intensive care at Ford Hospital in the heart unit, in their acute care. The girl came in with the red telephone and tells me the people from Social Security are calling, and they want to talk to you.

My wife had called them to cancel the hearing on the 30th of May and told them that I was in the hospital, and they called me and wanted a note from the hospital so I could get a hearing.

I just want you to know I'm proud of Senator Riegle, and I'm not just saying it because Senator Riegle did it. And like he says. Don't vote for a President who has no health care program. Don't vote for a Senator who doesn't take a stand on health. Don't vote for a Congressman who doesn't have a stand on health.

Write to your Congressman, write to your Senators, because the swing door will be closed. So let's get behind Senator Riegle. Let's get out and campaign and do it. I want to get the people behind us.

I went to the vice president of a major Michigan association. I go there and talk. I got everybody to sign a petition and take the petition to the Senator's and Congressman's office for Medicare legislation, because we've lost more money in costs by the stroke of Reagan's pen and now we have to go to Congress to get everything else taken care of.

I'm getting excited now. Sorry. But he's given us a 3 percent raise in benefits. Gave it. Raised our Medicare 4 percent. We're still 8 percent behind with Reagan. Why every time the Nation gets in trouble they say we got to take away the Medicare, take away from Social Security? I'll give 10 percent of my Social Security if Reagan will give 10 percent of his total wages whatever it is.

Thank you.

Senator RIEGLE. If we're going to get everybody in, everybody is going to have to stick to about 2 minutes here. I am reluctant to say that but that's what we're stuck with.

Rita, can you summarize for us? And then anything more you want to put in the record we will, but why don't you start?

STATEMENT OF RITA GULLETTE

Ms. GULLETTE. Thank you, Senator Riegle. I am Rita Gullette. I worked for 27 years and my eyes gave out. Social Services tried to

help. I lost my Medicaid after 5 years in 1983 and have tried very hard to get it back. I don't want to take too much time, but I thought you might know what people in Michigan have to go through.

I also applied for Social Security about six times. I keep getting turned down. I can't even get examined by a doctors. They just turn me down. They don't try to diagnose my health problems, and all I get told is that they haven't paid 50 percent of my bill. That's why I'm not in a wheelchair. I can't pay the bill.

But I'm not able to work. I haven't produced in some time. I have been told that I have ovarian cancer. I get Medicaid. I can't get in to see a doctor now. I could go see a new doctor and run up a fourth bill, but I can't get any long-term help. Every 3 weeks out of 4 when I have my period I bleed for three weeks. I am diabetic and I have a collapsed right valve. I have osteoporosis. They keep telling me that I can work, and I know I can't do it.

Senator RIEGLE. Let us see if we can't help you. The people that tell you to go work, if they had half the things you have, they wouldn't be working.

Ms. GULLETTE. But when I go to Social Security, Senator Riegle, and try to see a doctor, the doctor doesn't even examine me, and when I take along CT scans to show and prove that, they won't even look at it.

Senator RIEGLE. Well, you let us help you with it. Would you do that?

Ms. GULLETTE. All right.

Senator RIEGLE. I'm going to have one of my staff members talk to you here and let's see if we can't give you a hand.

Ms. GULLETTE. Senator Riegle, you are the only one who has offered to help me. I have gone around other elected officials and I didn't even get an appointment from these people.

Senator RIEGLE. Well, you are going to get an appointment from us.

Dolores Howell.

STATEMENT OF DOLORES HOWELL

Ms. HOWELL. Good afternoon. I am representing people who have a silent catastrophic illness. It attacks one in ten. It's a chronic mental illness. It doesn't attack only the old. It hits people in the prime of life.

My son has this mental illness. He has worked 12 years in the post office. He also has been a member of an HMO. He's been a member since 1981 of Group Health.

He was told he had exhausted his lifetime benefits of coverage in the hospital for mental illness. He's only 34. This is a discrimination against mental illness. As a member of the Alliance for the Mentally Ill, we are fighting that segment of discrimination determination, and we hope you will include that in your act. Thank you.

Senator RIEGLE. Thank you. Be sure to talk to the staff to see if we can help in some way.

Ms. HOWELL. I am in touch with someone.

Senator RIEGLE. Doris.

STATEMENT OF DORIS WILLIAMS

Ms. WILLIAMS. Thank you, Senator. I would first off say I am at the Plymouth Square apartment building. There are 16 units on each floor, and it's 14 floors in case there should be a petition to sign for this national health plan. I think it's a great idea, and I do have a very serious family problems.

I have a sister. She will be 76 in a few weeks, and she has Alzheimer's disease, plus she's diabetic which creates a blood pressure problem, and now she's losing her eyesight and she can't hear very well.

So she says I want to go clean with my son. So I took her over there and her grandchildren. Of course, the national health plan would help the Nation. Her son is a war victim, and he is on disability. He is talking as if he can't handle it.

So now I got to go over and try to get her in a nursing home, and I hope the hospital insurance plan will include nursing homes for people. Or how can you get them? She doesn't have a Medicaid card, and it's very difficult to get it. She has a red, white and blue Medicare card, but then they got to prove your age, and she has a Social Security card, voting card. She has all these things. I took her all these places to get them.

Now, I'm going to try to get her in a nursing home in Ohio because her grandchildren live there and my other sister and brother live there, and it's getting very hard to even get into a nursing home, and I hope the plan includes that.

And if there's any petitions to go around, we have plenty of good people in my building that like to get names.

Senator RIEGLE. Doris, thank you very much. Thanks for coming. Thanks for helping your sister. I know that's not easy to do.

Rabbi Markham or Nona Gray.

STATEMENT OF NONA GRAY, REPRESENTING RABBI JEREMY MARKHAM

Ms. GRAY. Senator Riegle, to your staff, and to my sisters and brothers who were kind enough to come out today and meet with us, I am here to represent Rabbi Jeremy Markham and myself.

For myself, I live with my father. In January 1987, on the 16th he was taken to the hospital over on 2730 Martin Luther King Drive. We took him there only to be built up and to have fluids. This is all that was supposed to have been done to him, but in the process, and I'd like to say in the process of being greedy, they done some tests on him.

And in the process, they had an intern to do a process and they punctured his lung, and from then, all the way from the 15th of January through the 22 of August, they punctured him three times. They punctured him trying to work on his prostate glands on July 3rd. They punctured him again—they say he was gasping for breath. If they are gasping for breath, they are supposed to do a tracheotomy which is the throat. But instead of doing a tracheotomy, they punctured him on the left side of his neck.

All they were trying to do is put an IV through into the artery, and in the process of doing that, right by his heart, they hit his heart, hitting his heart and he had a massive heart attack.

So I can only say I want to direct your attention to let you know there are people here who have suffered the worst kind of trauma. They don't know what to do. They don't know who to turn to. Now, I have had this experience.

Now, we have plans of a private lawsuit and we're going to sue the hospital because we had to pay all from January until the day he died. The day he died somebody was telling me take him home, take him to a treatment center.

During this we went to social services asking them for money for my mother who is 86-year-old and they said she is not eligible for anything. And what little they could give her would be in food stamps which would cost $10 a month.

I will do the best I can to care for her. She needs someone in the house during the day as well as at night. She needs a nurse or a housekeeper. I am doing the best I can to find her one without losing my job. I cannot care for her.

But I do feel at that age, she should get something. They should get someone out for her. I will do what I can do, but I cannot stop working. So I'm glad to see you so you can see what sort of problems exist because it is very hard.

I'm not a very good speaker. I'm not very much of a politician. But when it comes to God, I have my faith in God, and I do believe that you help us, and all the citizens here today have faced some trouble and they are showing you.

I am going to say God bless you for coming. Thank you. [Applause.]

Senator RIEGLE. Thank you for coming.

STATEMENT OF DOROTHEA JACKSON

Ms. JACKSON. Thank you, Senator Riegle, and your staff. I am Dorothea Jackson, one of your constituents from Detroit, MI. I have lived and worked in Detroit in three separate jobs, both at the YWCA as a staff director and teenage program director in the Detroit Public Schools for 34 years and in Wayne State University Graduate School teacher training.

I only have time for some of the things that I intended to relate because of the lateness of the hour, in the positions that I had in curriculum and as a consultant in the Detroit Public Schools, I taught young students who were supposed to be learning disabled and mentally deficient, but the problems were actually triggered because of emotional problems that they had because of situations at home, and some of them were connected with drugs and some of them got into various kinds of difficulties.

I actually abhorred the situation that youngsters have to take guns to school because I know that there is fear and the kinds of things that they have to put up with in the home and in the streets are absolutely deplorable.

But this does not relate particularly to health. After 36 years, as I said, in public service with the schools and in the university, I went to the Social Security office, and this is a personal matter that I have, to state the fact that I would be retiring. I made out the forms, of course, for the State, and after completing them, was

told to come back and state the exact time that I would retire and sign up for Medicare.

I did not fill out the form that the United States office in Maryland requires, but a few weeks later I received a letter and a form from the office in Maryland indicating that I should make out the form and return it by no later than about a couple of months before I was actually supposed to retire.

I found out that they had sent me the red, white and blue card with no hospitalization on it, and just about year before I had an automobile accident on I-94, and of course, I was getting medical help on our insurance from Blue Cross and Blue Shield as well as the car insurance.

But something happened. As soon as you get Medicare, they become the main carrier. When I got a denial of hospital and medical care from Blue Cross and Blue Shield, they said that Medicare would take care of that.

I went back to the Social Security office several times, but until I retire, they would not write it up. I retired April 1, 1986, and from that time, I have not received my Medicare coverage, and Blue Cross/Blue Shield says they have a cosponsorship with Medicare.

Blue Cross/Blue Shield had taken care of that when I was working. At this point, I am awaiting an answer from them. After I wrote back to them, they enrolled me as of 1987, July 1987, which means in that interim I have about $5,000 worth of doctor's care because I had to have theraphy and medical attention. Both bills have not been paid, and I have not obtained any answer to take care of that.

They are supposed to back-date the enrollment that they failed to take care of.

Senator RIEGLE. I don't know whether my staff has been assisting you on this or not. I gather not. Why don't we have somebody check with you right now and let's see if we can't give you a hand on this.

Ms. JACKSON. Thank you very much.

Senator RIEGLE. Our last speaker tonight is Reverend Arthur Carruthers, Senior. We are pleased to have you with us, and we'd love to hear from you now.

Mrs. JACKSON. Senator, excuse me. I was wondering if you would give us the names of your very wonderful staff who have been working all afternoon.

Senator RIEGLE. Fine. Inez Brown runs my office in Flint, and also is in charge of all my offices in the State of Michigan. David Krawitz who is seated beside me, is my executive assistant and assists me on the Senate Finance Committee and is responsible for health programs. Joan Huffer who is seated here to my left assists me on the Budget Committee and is also one of my top professional staff people.

There are a host of other staff people you've seen around here today. I promise you they are all hard workers and they have good hearts as well. [Applause.]

STATEMENT OF REV. ARTHUR CARRUTHERS, SR.

Reverend CARRUTHERS. Senator, first of all—and I am going to be brief—I want to thank you for taking the time to come here to witness the various things that go on with the elderly. I am the pastor of New St. Paul's Church in west Detroit.

In our parish among our parishioners, we do have quite a number of aged people who are recipients of Medicare or Medicaid and have to rely on that and only on that. On several occasions we have taken some of our members to the hospitals where they will either turn them down or where they made them wait hours and had to go home regardless of how sick they was, what their condition was because they couldn't stay any longer. They didn't have to put them on hold.

Our system is being very uneven to the people who have been the backbone of this America. People who worked when there was not enough money to even sustain the expenses much less to talk about building any kind of money for retirement age or not enough to pay any insurance.

When they tried to make enough money to raise up and buy insurance, they were too old to work, 40 years old, and we don't need you. These people are many of those who are among you who now are relying on Medicare and Medicaid to be sustained.

One of my members just the other night was taken to the hospital here in the city. He was transferred some 15 miles away some place to some hospital because the doctors and the nurses at the hospital and what-have-you would not take him in.

So, Senator, I appreciate your coming, and we trust if you need our support, as a minister, and among the people here in the city of Detroit, I am willing to do foot work to help get things done because it makes you frightened to grow old to see how conditions are now, and what will they be like in the future. [Applause.]

Senator RIEGLE. Reverend Carruthers, thank you.

I want to thank everybody. We have one fellow who wants to make a comment. I guess we have two that do. Then I have to step out. Channel 4 wants to do a live interview on this hearing today so everybody in the community can find out about it. So as soon as you've made your comment and you've made yours, I'm going to step right out there because they're all set to go apparently.

Mr. HOBBS. OK. My name is Julius Hobbs. I am a volunteer of United Way. We didn't get here in time to make a presentation like we wanted to. I would like to make an appointment so that you can get together with our director.

Senator RIEGLE. Good.

Mr. HOBBS. Also I would like to emphasize that I am going to a fund drive right now to make sure every child has a good Christmas and to make sure every child has something for Thanksgiving. Anything you people can help in that aspect is greatly appreciated. Thank you very much.

Senator RIEGLE. Good. Why don't you stick around and we can chat a little bit. This is going to take about 5 or 10 minutes once I step out of here to do this. Maybe we can talk at that time.

Yes.

SPEAKER. Thank you very much. I would like to express my problem. I may have trouble speaking.

Senator RIEGLE. We'll understand. You take your time.

SPEAKER. I would like to say to you that I'm from Romania. I have been here for 7 years since 1980. From the first day I appreciate it. I could not afford to step out and work because I didn't know English in the beginning even if I worked. I had to go to the university to get English.

Now, I hired to work cleaning this office for low pay to see how one should work in this country. I would like the opportunity to teach and give to the poor what I have learned.

I would like consideration for people with special problems. I would recommend the book "The Closing of the American Mind."

Senator RIEGLE. I'm going to have David talk to you about this now to see if we can be helpful in some way on this.

I'm going to adjourn the hearing now, but I want to say to all of you who have been here and those of you who have spoken and those of you that have not spoken how much I appreciate the fact that you've come, that you've been part of this. This is democracy in action. We've got a transcript and we'll print every word of what's been said here today. I'll share it with my colleagues in the Senate, and we're going to push on until we get these problems solved.

The committee stands in recess.

[Whereupon, at 5:05 p.m., the committee adjourned.]

SOAR* Coalition of Michigan

"Representing Over 70,000 Active/Retired Federal and Postal Employees"

P. O. Box 37321, Oak Park, Michigan 48237

November 11, 1987

Senators:

My name is Peter Romanelli. I am the chairman of the S.O.A.R. Coalition of Michigan. S O A.R. is an acronym for Save Our Annuity Retirement. I represent over 70,000 Active and Retired Postal and Federal Employees in the State of Michigan.

I am here to speak against the Senate Bill 1127, the Medicare Catastrophic Loss Prevention Act of 1987 as it was originally written. Yes I know that this Bill has been amended in the Senate but it must still go before the Senate and House Conferees and when it gets there anything can happen because the House Bill differs so much from the Senate Bill as amended. I am here asking that you support your amended Bill all the way.

This Bill. 1127, as originally presented means that all Postal/Federal retirees would be charged for health benefits they already have under the Federal Employees Health Benefits Plans. As was proposed. this would mean retirees pay twice for the same benefits. This is double coverage and unnecessary.

The average out of pocket costs for senior citizens over 65 is $3 000.00 per year. That is a big chunk of their retirement income. Catastrophic care as originally proposed and passed in the House is not the answer for us as far as government employees are concerned. All we ask is fairness and equality. Is this asking too much? We just received another increase in our Health Benefits Plan premiums with no increase in benefits. We have to keep it,

*Save Our Annuity Retirement

we cannot afford to drop it because as a retiree, once we drop our Health Benefits Plan, we can never take it again.

Why is it everytime it comes to cutting something or taking away something it is always taken away from the Postal/Federal Employees. Two years ago under the guise of the Gramm-Rudman bill our C.O.L.A. was not given to us, this application was ruled illegal. This was not taken away from the Social Security people. All we are asking for is equal treatment, is this asking too much? Do you realize that the Postal/Federal retirees would pay about eight times as much in premiums as the Social Security retirees who receive the same retirement income. Again I ask, is this fairness and equality? Just because we pay taxes on our Civil Service Annuity does that mean that we have to pay extra to get something others receive for nothing.

A suggestion was made to me that I could drop my Medicare, why should I drop something I have already paid for. As I stated before I cannot drop my FEHBP plan in favor of the catastrophic care because the catastrophic care provides less coverage than the FEHBP.

I would like to thank you for your time and consideration and allowing me to express my views on this most important subject. this is somethin that affects each and every retired Postal and Federal employee.

Sincerely,

Peter Romanelli

Peter Romanelli, Chairman
SOAR Coalition of Michigan
17646 Lenore
Detroit, Mi. 48219

Community Centre Group
Distinctive Healthcare Facilities

August 24, 1987

Dear Senator Riegle:

Thank you for the opportunity to comment on potential developments in the long-term care insurance industry.

Community Centre Group owns and operates eight (8) long-term care and assisted living centres in six (6) different communities throughout the State of Michigan. Our firm provides employment for 402 people and cares for a total of 541 residents in these facilities.

We are all aware that the elderly population is growing dramatically. In order to meet the healthcare needs of these people in the future, we feel any type of insurance should cover the different levels of care and assistance which are now available; these are:

1. Home Healthcare
2. Adult Foster
3. Homes for the Aged
4. Nursing Home

By offering different levels of care, the resident receives the appropriate care at the appropriate cost.

Our Company supports long-term care insurance, because if allows individuals the method for providing the resources to plan for a dignified retirement.

Modern medicine and an improved healthcare system have lengthened lives, however, too often the past defects of inflation has devastated the estates of many elderly, forcing these people into government welfare programs.

Long-term care insurance would relieve the government of this obligation which is becoming increasingly difficult to fund and administer.

Thank you for the opportunity to comment and your sensitivity to the elderly population.

Sincerely yours,

Steven G. Bandstra
President

SGB/pr

950 Taylor Street • Grand Haven, Michigan 49417 • (616) 846-5930

C.R.A.C.
Community Resource
and Assistance Center
16334 East Warren Avenue
Detroit, Michigan 48224
(313) 925-0103

November 11, 1987

Senator Don Riegle
c/o Cecelia Walker
1850 McNamara Federal Building
477 Michigan Avenue
Detroit, Michigan 48226

Dear Senator Riegle,

Representatives of the Community Resource and Assistance Center were unable to attend your hearing on Catastrophic Health Care for Seniors, the Uninsured and Underinsured. We thank you for caring and for holding the hearing. We want you know of our support and offer our written testimony and suggestions.

CRAC as a service provider of door-to-door transportation, nutrition programs, and information and referral programs for the elderly and handicapped has been acquainted with many of the needs and concerns of Seniors. As a result of our experience, we support the positions of the Area Agencies on Aging Association of Michigan.

We do feel that most proposals in both the House and the Senate fail to address the most pressing health care need of the elderly and that is long term services such as home health care and nursing home care. Most elderly persons are more likely to need long term care than extended hospitalization benefits.

CRAC supports the prescription drug benefits offered in HR 2470. We believe that it will help many who face incredible bills for prescriptions. For over 75% of the elderly population the cost of prescription drugs is their largest health care expense. The elderly use three times more prescription drugs than other age groups and account for 30% of all drug expenditures even though they make-up only 12% of the general population. We also support the spousal impoverishment benefit that would require states to allow spouses of Medicaid nursing home patients to keep at least $925 in monthly income and $12,000 in liquid assets. This would enable spouses to live independently in the community and still assure the other spouse nursing home benefits from Medicaid.

We also support the new respite care benefit provided in the House proposal. Although modest in requiring only 80 hours pe year, it is a first step in assisting the primary careg s of long term care to the elderly, the family. The modest increases in home health care and nursing home benefits are welcome even though they do not adequately address the need for long term care. We appreciate the elimination of the three day prior hospitalization requirement and the drastic reduction in the copays for skill nursing care.

We feel that the entire cost of the catastrophic care proposal should not be borne by the elderly themselves but must be spread to cover potential beneficiaries, namely every working citizen in the nation. In this way coverage would be made affordable for all. We are concerned however about the lack of a cost control mechanism for outpatient care, physician services, laboratory services and prescription drugs.

We hope that our concerns will be helpful to you to improve health care for our residents and the elderly throughout the nation. Now if there is anything that you can do about obtaining help for door-to-door assisted transportation that allows the elderly to go to medical appointments, hospitals and to obtain the presciptions, we would be most grateful. It is the number one concern of both care providers and the elderly in the Detroit area.

Thank you for your help now and in the past.

Sincerely,

John A. Slater

John A. Slater
Executive Director

Detroit City Council

Detroit, Michigan 48226

MEL RAVITZ
COUNCILMAN

October 27, 1987

The Honorable Donald W. Riegle
U.S. Senator
Senate Office Building
Washington, D.C. 20510-2210

Dear Don:

Thank you for the opportunity to testify at the Senate Hearing on health care issues on Wednesday, November 11, 1987. Because I will be unable to attend, I'm sending this note along with a few attachments that present my views rather effectively.

Specifically, I support Representative Pepper's H.R. 65 as well as the Pepper-Simon plan (S1616) and H.R. 2762. I oppose strongly the provision of S1127 that requires seniors to pay the entire cost of the new coverage rather than use the social insurance method which shares the burden. I urge you at least to work to achieve the social approach in S1127.

Finally, my basic views of the proposed so-called "catastrophic" bill presently before the Congress are well expressed in Representative Beilenson's article enclosed. "Better than what we have" is not good enough, especially if it will be an impediment to a truly comprehensive bill.

I hope the hearing goes well. I truly regret I can't be present.

Sincerely,

Mel Ravitz

MR:ab

cc Senator Carl Levin
Representative Sander Levin
Representative John Conyers
Representative George Crockett

Enclosures

Detroit City Council

Detroit, Michigan 48226

MEL RAVITZ
COUNCILMAN

August 31, 1987

Senator Donald W. Riegle
Senate Office Building
Washington, DC 20510-2201

Dear Don,

I understand that the House has recently passed a so-called catastrophic health care bill that has many serious shortcomings-including requiring seniors to pay the entire cost of the new coverage rather than use the social insurance method which shares the burden.

Please work to correct this deficiency in the Senate version S.1127. Also, please keep or improve upon the House plan to cover prescription drugs and, most important of all, add long term nursing home and extended home health care to the bill. These latter benefits are the crucial ones that would help so many people.

Sincerely,

MR:cp

RESOLUTION BY COUNCILMAN MEL RAVITZ:

WHEREAS, The enormous problem with rising health care costs in this country affects the senior citizen population the hardest because of the greater needs of this population for long term nursing care; and

WHEREAS, Statistics reveal that in the next year over 500,000 older Americans will be forced into poverty by the cost of catastrophic illnesses which are not covered by Medicare; and

WHEREAS, Representative Claude Pepper has introduced H.R. 65, the Catastrophic Health Insurance Act of 1987, which provides financial protection against the extremely high costs of catastrophic illness including nursing home care and prescription drugs, and

WHEREAS, H.R. 65 would provide Medicare recipients comprehensive catastrophic health care coverage while requiring the average senior to spend no more than $800 a year or 10% of their income for all their needed health care. **NOW THEREFORE BE IT**

RESOLVED, That the Detroit City Council endorses and supports H.R. 65 as the most comprehensive legislation that has been offered to provide financial protection against the devastating costs of catastrophic illness. **AND FINALLY BE IT**

RESOLVED, That the Council calls on members of both Houses of Congress to support H.R. 65.

DATE APPROVED _____

A Catastrophic Bill

[By Congressman Anthony C. Beilenson, Democrat from California]

This was going to be the year the Federal government finally did something to protect the elderly and their families from the financial ruin a major, long-term illness can cause. But unless Congress substantially alters the "Medicare Catastrophic Protection Act" that the House passed in July, older Americans will not get the benefits they are expecting from this bill.

Despite its title, the bill the House approved does not cover the most common catastrophic expenses incurred by the elderly—those associated with long-term nursing home or home health care. Yet it is precisely the cost of such care that everyone fears the most, because it bankrupts all but the wealthiest. 53 percent of the unmarried elderly become impoverished after just 13 weeks in a nursing home, 83 percent within a year. The bill does cover the exorbitant cost of a long-term hospital stay, but fewer than half of 1 percent of all medicare recipients are hospitalized long enough to use that benefit. It would also provide some additional help with physicians' fees, pay for part of the cost of prescription drugs, and extend a minor amount of coverage in a few other areas. Those benefits are really just marginal add-ons that would be used by only a small fraction of beneficiaries.

For the modest additional benefits provided in this legislation, medicare recipients would be charged an enormous amount. Along with the higher basic premiums that all beneficiaries would pay, millions would also have to pay a new "supplemental" premium. By 1992, a beneficiary with an adjusted gross income of just $15,000 would pay almost $1,400 in total medicare premiums compared with $312 under current law. That is a lot more than anyone should have to pay for the small increase in benefits the bill provides.

At least one-third, and perhaps more than half, of the cost of the new program is due to the new prescription drug benefit. But pharmaceutical bills don't normally bankrupt the elderly. Moreover, the drug benefit is not cost-effective. A huge amount of paper work would be necessary to process tens of millions of prescriptions.

Worst of all, passage of this bill would only make it more difficult to achieve true catastrophic coverage. Having just approved a new package of benefits that will cost $10 billion a year by 1992—and possibly $30 billion by 2005—Congress is going to be reluctant to provide for the even more expensive coverage of nursing home and home health care. To do that will require either imposing even *higher* premiums on beneficiaries, raising taxes, or increasing the already intolerable federal budget deficit.

The Medicare Catastrophic Protection Act is an example of good intentions that went astray. We wanted to protect Americans from the financial devastation of catastrophic long-term illness, but ended up, instead, with a bill that would add billions of dollars' worth of marginal health care benefits, and which would help only one segment of the population, the elderly.

Congress needs to go back to Square 1. A better approach would be to create a true catastrophic insurance program for all Americans, young and old. As many as 40 million Americans under 65 have no health insurance, and many more have no catastrophic coverage. Although younger people have a much smaller incidence of long-term illness or disability, they too risk financial devastation if they lack insurance.

Congress should work to ensure that no American will be destroyed economically by the costs of a major long-term illness. A federally sponsored program covering truly catastrophic health care expenses and available to people of all ages would require very small premiums, because its cost would be spread among a much larger population that has a much lower incidence of need for such care. That kind of program would be far better than the expensive marginal benefits provided in the Medicare Catastrophic Protection Act.

[From Saving Social Security, October 1987]

Guest Editorial

[By Senator Paul Simon, Democrat from Illinois]

Middle-income families needing long-term care for chronically ill seniors or other family members today basically face three choices: exhaust the household's resources or take on crushing debt; become paupers to qualify for Medicaid help; or do without adequate care. None of these "choices" is fair.

Now Congress has before it a fourth choice: Expand Medicare insurance to cover long-term home care.

President Franklin Roosevelt led the fight for Social Security to free all Americans from the fear of an old age of poverty and dependence on others. Social Security was set up as a social insurance program, so that a secure old age would no longer be the privilege of the rich, but the earned right of every American.

A quarter-century later, President John Kennedy proposed another great step forward: Medicare.

He saw that ordinary Americans were being denied the right to live out their retirement years in health, because only the rich could afford high-quality health care. He saw that ordinary Americans were losing the security and independence they had worked a lifetime to earn.

Medicare, like Social Security, was created as a social insurance program, so that every working American who pays into the system will earn Medicare benefits. In the American tradition of fairness, Medicare provides that a healthy old age no longer is the privilege of the rich, but the earned right of every working American.

But today, we face a new challenge, because Medicare provides virtually no protection for older Americans who need long-term nursing care, either at home or in nursing homes. It provides no help to the wife whose husband needs round-the-clock attention because of Alzheimer's Disease.

It's not right that after losing a lifetime of hard work, of supporting yourself and rearing a family, that the onset of health problems should cost you your independence. But that is precisely what happens to many older Americans.

By failing to provide help, we also impose huge financial, physical and social burdens on many families.

Although most Americans do not realize it, Medicare will not pay for long-term care. Before Medicaid can help, individuals or couples must exhaust their own resources, becoming poor enough to qualify by "spending down" their income, savings, and other assets. Long-term care usually saps the life savings of even the thriftiest middle-and lower-income families with brutal speed and forces countless seniors to close out their lives as paupers.

Eighty percent of catastrophic health care expenses are for long-term care provided outside of hospitals, and first-year costs for those who must go to nursing homes now average $22,000. To meet these costs, families often are forced into bankruptcy or poverty. Half of all nursing home residents lose all their savings and property before the first year is over.

Harvard Law School researchers, studying the issue of long-term care in nursing homes, found in 1985 that nursing home costs would bankrupt 46 percent of a sample of single 75-year-olds in Massachusetts in just 13 weeks. By the end of a year in a nursing home, 72 percent would have nothing left.

Of married Alzheimer's patients getting care at home, 47 percent are impoverished within the first year. And millions of seniors with crippling arthritis or other chronic conditions requiring long-term care at home get no protection. Simply stated, the costs of long-term care at home are beyond the reach of the typical working or retired household.

Unfortunately, the separate "catastrophic care" legislation under discussion in the Congress also leaves the question of long-term care unanswered.

Present policies rupture families that should be permitted to stay together. The tie that binds is being pulled apart by the need for long-term care. Couples who have lived together for decades find themselves separated by a society and government too insensitive to understand the misery and heartache caused. The reality is that we let too many seniors live without the independence they cherish. They go to nursing homes because there are no alternatives.

To provide long-term care opportunities of quality without fear to seniors, and without crushing their families in debt is clearly a national need today and will become an even greater need tomorrow.

As a first step, I have introduced in the U.S. Senate the Long-Term Home Care Family Protection Act (S. 1616), a plan sponsored in the U.S. House of Representatives by Rep. Claude Pepper (H.R. 2762). For the first time Medicare health insurance would be extended to cover long-term care needed by millions of chronically ill seniors and other family members. The Pepper-Simon plan opens new options for home-based care and community-based assistance for that 30 percent of nursing home residents who really would not need to go to nursing homes if there were better alternatives.

The Long-Term Home Care Family Protection Act defends families against the catastrophic costs of chronic illness for seniors, working-age Americans and children needing home care. The plan recognizes that long-term catastrophic home care costs are not simply a problem for older Americans but also for millions of young families crushed by debt in caring for parents or other family members. Home care assist-

ance would be available under the act only when prescribed as essential by a physician and would be closely monitored and managed to assure efficiency and cost-effectiveness. Coverage could include nursing care, homemaker and health aide services, physical therapy, respiratory therapy, personal care services, medical supplies and durable medical equipment.

The Long-Term Home Care Family Protection Act is fully and progressively self-financed. The new home care benefit would be completely financed by eliminating the cap ($45,000 in 1988) on income subject to the Medicare payroll tax of 1.45 percent. This change would affect only those five percent of workers who earn more than $45,000 in individual income (not family income). The change would generate approximately 46 billion each year over five years. The bill specifically prohibits use of any general revenue funds or other Medicare trust fund monies to pay for long-term home care. The deficit would not be raised one cent.

One of this nation's finest leaders, Hubert Humphrey, said it well:

"The moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadows of life—the sick, the needy and the handicapped."

I heard Hubert Humphrey make that statement dozens of times and it always sounded good and right to me.

This good and great nation can do better in meeting that test, in giving older Americans and their families the choices they need to face the challenges of long-term health care with confidence and dignity. And I believe we will do better.

JVS
Jewish Vocational Service
29699 Southfield Road • Southfield, MI 48076-2063 • (313) 559-5000

November 16, 1987

Office of Senator Don Riegle
1850 McNamara Building
Detroit, MI 48226

Attention: Ms. Cecelia Walker

Dear Ms. Walker:

I was unable to attend Senator Riegle's recent public hearing on catastrophic health care for seniors, but wanted to express my viewpoint. Although I realize that rising health care costs impact negatively on most people, I feel that senior citizens on fixed income are especially vulnerable, particularly with their tendency to acquire additional medical problems with increasing age.

The enclosed photocopy of a letter received by one of my clients illustrates the existing problem. As you can see, Health Alliance Plan is raising their monthly premium for "Senior Plus" by nearly 100% and increasing their prescription co-pay by 150%. Many seniors, upon receiving such letters, feel unqualified to "shop around" for a more reasonable alternative and agree to pay the increased cost. Eventually, this cost may become prohibitive, resulting in the individual cancelling insurance which he or she truly needs.

As an individual who works with senior citizens on a daily basis, I support any efforts to contain the cost of medical care for this segment of the population.

Sincerely,

Fran Cook
Senior Adult Workshop
Herman Teitel Senior Adult Workshop

FC:pce
Enc.

Albert I. Ascher
Executive Director
Barbara R. Nuremberg
Associate Executive Director
MEMBER: JEWISH WELFARE FEDERATION • UNITED FOUNDATION
RECIPIENT: ALLIED JEWISH CAMPAIGN • UNITED FOUNDATION TORCH DRIVE
COUNSELING SERVICES APPROVED BY INTERNATIONAL ASSOCIATION OF COUNSELING SERVICES, INC.
ACCREDITED BY THE COMMISSION OF ACCREDITATION OF REHABILITATION FACILITIES

hap
Health Alliance Plan

2850 W. Grand Boulevard Detroit, Michigan 48202 Telephone 313/872-8100 A non-profit corporation

October, 1987

872538 DL [redacted]
15100 W 10 MILE
OAK PARK MI 48237

Dear Senior Plus Member:

IMPORTANT INFORMATION REGARDING YOUR PREMIUM RATES EFFECTIVE JANUARY 1, 1988

The upcoming "New Year" will be bringing with it some changes regarding your current monthly premium rate and your prescription drug co-payment (when applicable).

A recent study was completed regarding Health Alliance Plan's Medicare Risk Program, Senior Plus. It was noted that several of the other local insurance companies and HMOs have had to discontinue programs similar to Senior Plus because of the high administrative operating and medical claims costs.

Rather than discontinuing the Senior Plus Program, Health Alliance Plan has made the following decision:

- We will continue to offer this program to interested members, however, in order for us to cover the costs of this program, it is necessary for us to raise the monthly premium rates and the prescription drug co-payment (when applicable).

THE NEW RATES WILL BE:

- **BASIC OPTION:** will increase from $18.00 to $25.00 per month.
- **MEDIUM OPTION:** will increase from $25.00 to $52.00 per month. Also, the co-payment per prescription/refill will increase from $2.00 to $5.00.
- **HIGH OPTION:** will increase from $28.00 to $55.00 per month. Also, the co-payment per prescription/refill will increase from $2.00 to $5.00.

(over)

BEST AVAILABLE COPY

We empathize with you regarding the impact that this rate increase may have on your financial situation. However, in order to continue offering the Senior Plus Program, we have no other alternative but to raise our rates [illegible]

If you have any questions, feel free to contact our Member Services Representatives at [illegible].

Sincerely,

James Walworth

James Walworth, President
HEALTH ALLIANCE PLAN

IMPORTANT NOTICE

Due to the increase in rates, we would like to offer you the opportunity to change your option if you desire. In order to do so, simply check the box that indicates the option you want effective January 1, 1988.

PLEASE RETURN THIS LETTER BY DECEMBER 1, 1987. THIS CHANGE WILL BE EFFECTIVE JANUARY 1, 1988.

A self-addressed, postage paid envelope is enclosed for your prompt return.

[ ] BASIC OPTION - $25.00 per month - NO PRESCRIPTIONS, NO EYE GLASSES

[ ] MEDIUM OPTION - $32.00 per month - INCLUDES PRESCRIPTIONS, NO EYE GLASSES

[X] HIGH OPTION - $45.00 per month - INCLUDES PRESCRIPTIONS, INCLUDES EYE GLASSES

Signature: [redacted] Date: 10/27/87

Please [illegible]

BEST AVAILABLE COPY

Oakwood Hospital Corporation

Ms. Doreen Lichtman, MSW
18101 Oakwood Blvd.
P.O. Box 2500
Dearborn, Michigan 48123

October 29, 1987

Senator Donald W. Riegle, Jr.
Dirksen Senate Office Building
Washington, DC 20510

Dear Senator Riegle:

Due to conflicting schedules, I am unable to attend the hearing on Wednesday, November 11, 1987, concerning the "Catastrophic Health Care for Seniors."

From my professional experiences with the elderly, I have found that their economic burden begins when an older adult needs home care, day care, or both in order to still live at home and maintain a dignified life. Their funds can be depleted fast with the high cost for good care.

When the caregiver tries to do everything for a chronically ill, dependent person because of depleting or lack of funds, the chances of "caregiver's burnout" increases by twofold. So now we have two victims, the ill, dependent person and the one trying to carry the full burden of care.

Many elderly are kept at home for as long as their money lasts and then the caregiver is forced to place their loved one in a nursing home so medicaid will pick up the bill. If there was a health care program that would reimburse for home care and adult day care to help that elderly person maintain as much independence as possible, while giving the caregiver a chance to cope with their many extra responsibilities, I think there would be less nursing home placements and less family problems due to the extreme stress of caring for a loved one.

I hope this letter informs you enough to the immediate need for a change in our health care policies so we can guarantee a quality of life to the people in our society.

Sincerely,

Doreen Lichtman, MSW

To Senator Donald Riegle, Jr.

This is written in response to your Senate hearing on health care issues, focusing on catastrophic and long-term illnesses. We have received and reviewed both proposed bills regarding the above mentioned. We heartily agree that the substitute bill is superior to President Reagan's. However, the substitute bill does not address fully the discriminatory poverty level imposed on our nations elderly. This makes the deductable amounts an unreasonable burden for many elderly. It is well known that health care costs have risen along with the deductables, while the elderly are living longer their income remains unchanged. Many phycians have chosen not to adhere to guidelines set forth and charge beyond the accepted reasonable amount. Our nation's elderly have made many contributions to this country, including their physical and financial support along with dedication to freedom. They do not deserve to be priced out of their retirement years by the generations they have selflessly insured. Maybe we should re-evaluate our nation's health care delivery system rather than placing the burden on our elderly. We believe the poverty level for senior citizens should also be re-evaluated.

Focusing on catastrophic and long-term illnesses also requires a serious look at nursing home care costs and home health care costs. These areas are inter-related and should be acted upon as such.

We agree with Rep. Claude Pepper of Florida, who said, "You can judge a civilization by the care it takes of its old and sick people." We question if our country can pass this test?

Thank you for your concern,

Stephen Potts

Carol Potts R.N. B.S.N.

Older Adult Ministry
Coordinators
Leighton United Methodist Church

PROFESSIONAL HEALTH SERVICES, INC.®
Community Care Since 1981

CORPORATE OFFICES
8137 W. GRAND RIVER
BRIGHTON, MICHIGAN 48116
(313) 229-0615

LIVONIA OFFICE
(313) 427-4090

ANN ARBOR OFFICE
(313) 996-1681

July 21, 1987

PREGAM CARE
SUBSIDIARY
(313) 229-2013

PROFESSIONAL
HOME HEALTH CARE
DIVISION
(313) 229-0615

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PERSONNEL SERVICES
SEARCH &
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(313) 229-0615

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OF INDIANA
(219) 726-6711

PROFESSIONAL
HEALTH SERVICES
OF CAROLINA
(803) 329-4250

INDUSTRIAL HEALTH
DIVISION
(313) 229-0615

HOMEMAKER DIVISION
(313) 229-2013

Senator Donald W. Riegle Jr.
SD 105
Washington, D.C. 20510

Dear Senator:

My name is Susan Lapham, I am the Marketing Representative and Field supervisor for Professional Home Health Care in Brighton. We are a full service, 24 hour a day, 7 day a week, Home Health Care Company.

I have attended your forum in Warren and Flint, listening to speakers on both sides. I am neither a business executive nor do I have a chronic illness. Which means I can't speak of personal Health and financial problems or can I quote financial and medical statistics. But I can talk about the client who if it weren't for Home Health Care would not get a hot meal, a bath, or general home cleaning. Or the young married woman whose husband has a job and insurance but they never expected medical bills for their baby to not be completely covered by insurance when they found that he had to be suctioned daily. and no one would help them.

We as all other Home Health Care agencies are called daily by a elderly man or woman desperately needing help. But their only income is social security which financially cannot allow them to hire help, and not always are they eligible for D.S.S.

Senator Reigle your idea for Health Reform is something I agree with, and while talking to many elderly about it have agreed. My hopes are that there will soon be relief tor people who are in need of help, getting it.

Sincerely,

Susan L. Lapham
Marketing Representative
Field Supervisor

Enclosure

SL/bm

SENIOR/LIFELINE
P.O. Box 123
Coveri, Michigan 49043

(616) 764-8378

S. Mae Lucas, Director

August 21, 1987

Senator Donald Riegle, Jr.
Federal Building
Grand Rapids, Mi 49503

Re: Catastrophic and long term health Care

Dear Senator Riegle:

My concern centers around the emotional effect and anxiety experienced in connection with long term health/catastrophic care cost.

Presently, a person getting ill has the horrible thought of all their assets, money in the bank, and worldly goods being used for their care.....and if they should get better ...:. where would they go and how would they live.

I service senior citizens, I think when a citizen has reached this stage in life, they should not have to worry about getting sick and how they will be cared for. We know, they will not live another 65 years - therefore, cut the "red Tape" make life in the golden years - really golden. Our country can afford to do this.

I hope that money will not be the only consideration in the care of long-term illnesses.

Sincerely yours,

S. Mae Lucas, Director
Senior Lifeline

SML:nsa

15660 Windmill Pointe Dr.
Grosse Pointe Park, Michigan 48230

November 5, 1987

U. S. Senator Don Riegle
Regional Office
1850 McNamara Building
Detroit, Michigan

Re: Public Hearing of November 11, 1987 on
Catastrophic Health Care for Seniors

Dear Senator Riegle:

I am writing with regard to your public hearing concerning Catastrophic Health Care for Seniors - the uninsured and underinsured - of Wednesday, November 11, 1987. I share your concerns with regard to this important subject, and it is my belief that the lack of coverage with respect to catastrophic illnesses for important segments of our country's population is an extremely important gap in the financial security system of our nation as a whole. I am very concerned however, and speaking as an actuary who specializes in employee benefits, that adequate financing be established with respect to the cost of any government funded or subsidized program of this nature. Of course a program extending a significant coverage like this to a large number of citizens will involve future costs which are very difficult to estimate, and which are of a somewhat open ended nature. As we all know a significantly greater proportion of our nation's populous will be in the ranks of the senior citizenry, especially following the year 2010. Insofar as the Social Security System is concerned, a certain amount of advance funding has been established under the current tax rate structure. I believe that it is very important that adequate actuarial studies be performed with respect to any program that is contemplated along these lines. It seems apparent there is now a substantial possibility of increased future costs to the working population during the next century with respect to programs which are already in place (e.g., Medicaid). I am also very concerned that the opening up of new programs may add to what may become a significant burden during the second quarter of the next century.

I would be happy to assist Senator Riegle with regard to any actuarial matters that may arise with regard to this program.

If you should have questions or I may be of further service, please do not hesitate to contact me.

Sincerely,

Samuel S. Stanley, F.S.A.
Actuary

SSS/mz

SUNSHINE HELPER'S CORPORATION
2250 PLAINFIELD, N.E.
GRAND RAPIDS, MI. 49505

August 21, 1987

Donald W. Reigle, Jr.
Fedral Bldg. Rm. 716
Grand Rapids, MI. 49503

Dear Mr. Riegle,

I was unable to attend your Senate Hearing on health care issues. I was glad to read that you would like to hear what we as first hand care givers experience, and what our concerns are on this issue and the policies we are taking to meet the communities needs.

With the escalating costs of nursing Homes, resident homes, many families are concerned about the future of their aging parents.

Our Parents today are healthier and live longer lives. They have dignity and are productive longer, with a little help can and deserve to remain in ther homes as long as financially and physically possible! Sunshine Helpers Corp have been providing quality assistance and hands on help in the home for those Seniors with alzheirmers & related Diseases who need that extra support to keep them independant in their home or families home by providing services such as:

Transportation to-from Dr., therapy,errands, shopping
Housekeeping
Laundry & Ironing
Basic care , Bath assistance
Meal Preparation
Medication supervision
Companion & relief for care givers

I would like to address the specific problem in aging: ALZHEIMERS DISEASE
Alzheimers disease is progressive, irreversible neurological disorder affecting a estimated 2.5 million American adults; most victims over 65.

Alzheimers is characterized by gradual loss in ability to perform routine tasks, impairment of judgement, disorientation, personality change, loss of thought & language.

Alzheimers Disease is devastating for both victim & their families. The course of the disease is usually several years, some of which may require total care regarding daily activities.

Caring for a person whose mind is going or gone can be and extraordinarily demanding & frustrating experience, taking tremendous stamina, fortitude, patience & love from the caregiver of someone with alzheimers disease or related dementing long term illness.

Families faced with care of a loved one with alzheimers often experience painful & conflicting emot ions they often find themselves in a depressed state.

SUNSHINE HELPER'S CORPORATION

2250 PLAINFIELD, N.E.
GRAND RAPIDS, MI. 49505

Sunshine Helpers policy has always been to be their ready to support & work with families and the needs of their aging parents with alzheimers and other related long term illness.

With the continuing changing needs & stages in alzheimers & aging parents many families have no choice but to keep their parent or loved one at home in the early stages. The time & energy involved may drain those resources from the caregiver, spouce and children.

So with the changes in the family unit comes a change in the families needs. Their may be times when family members need time out by themselves to do things that restore their spirits & perspective on life.

Sunshine Helpers understand those needs & provide caregivers relief and respite care on full or part-time basis.

We here at Sunshine Helpers Corporation want to encourage legislation that responds to the needs of Alzheimers Disease patients & Families, at all level of government to see the need of the some 2.5 million american Adults that are affected by alzheimers Disease.

By:

1. Assisting in in find funding for helping families with in home care of their loved one with Alzheimers Disease.

2. Assisting in providing day care centers. Set up to meet the needs of those with Alzheimers Disease. So when those Family member who have to work daily to support themselves can have that kind of support & care.

3. Continuing to administer research grant programs to initiate new discoveries in the causes, prevention and cure of Alzheimers disease.

Thank you for hearing our concern for care of Victims with Alzheimers Disease.

Sincerely,

Carolyn DeVries, LPN
Care Coordinator
Sunshine Helpers Corporation

SUNSHINE HELPER'S CORPORATION

2250 PLAINFIELD, N.E.
GRAND RAPIDS, MI. 49505

Dear Friend,

We are pleased you decided to call us for your "Helping Needs". SUNSHINE HELPER'S is a locally owned comapny and our primary goal is to provide our community with a basic reasonable service to meet all of the helping needs.

Our Sunshine Helper can assist you in many ways. Fix your meals, housework & laundry, run errunds, grocery shop. They can supervise and sit with seniors, accompany them to Dr. visits, assist with daily care & help them remain independant & in their own home by providing all of the above.

Our helper's have passed our screening & reference check, are bonded & insured by us, the SUNSHINE PEOPLE.

Our helpers are scheduled according to your needs and you will be billed for the time that our helper is there, whether is 2 hrs. for only transportation or 4-24 hours for housekeeping, care & assistance.

A Sunshiie Helper is a truely necessary person in our Community. Not only will they come to help you with the basic needs for homemaking but they will be available whenever you need them, as their schedule permits.

Just think of it; a pleasant smiling SUNSHINE HELPER who will come when you call and one of the nicest factors of it all is that it doesn't cost a fortune!

Our costs are not only reasonalble but will save you the time & frustrations of finding someone to help you occasionally.

Our SUNSHINE HELPER'S will provide the basic help & care you need as well as their own smile.

SUNSHINE HELPERS. "THE PEOPLE WITH THE HELPING HANDS" ..... For reasonable rates and exceptionally high standards.

ADD A LITTLE SUNSHINE TO YOUR LIFE !!!

Sincerely,

Your Sunshine Helper's

Ed Kind

STATEMENT OF BOARD OF DIRECTORS, AARP CHAPTER 170, GRAND RAPIDS, MICHIGAN

At its August meeting the board of directors of AARP, Chapter 170, Grand Rapids, asked that the following concerns be relayed to Senator Riegle concerning Catastrophic Health Cares

1. Provisions for extend long-term nursing home care have not been addressed.

2. The deductible of $500.00 a year for out-patient prescription drugs is not realistic. The average senior spends about $370.00 per year for prescription drugs, thus four out of five would not be helped at all.

3. The proposed additional premium of $2.30 a month for the drug coverage is manageable now, but there is no cap on future premiums. Seniors would be paying drug bills for the general population with disabilities via Medicare premiums. For example, Medicare fees would be utilized to pay for AIDS treatment at the approximate cost of $10,000 per patient per year. This could lead to the same problem that Social Security when it expanded its umbrella far beyond its original intent. National problems should be addressed by the government as a whole, not assigned to a single population group.

4. In view of budget constraints, a surtax will be necessary but the income level at which the surtax would take effect has been lowered considerably since the original concept and is at a level that would still pose a hardship on many seniors. It is tantamount to a means test which AARP has previously opposed. In the Fifth Congressional District it would affect half of the senior population.

5. Generic drugs should be required where applicable.

6. We strongly support the provision for spousal impoverishment protection.

7. We support the concept of an increased tobacco tax to help fund the increased coverage in Medicare. There is no reason why a few tobacco producing states should hold this funding source hostage.

Statement prepared by: Hazel Baar
Hazel Baar, president, Chapter 170, AARP
Carl Poll, Legislative chairman, Chapter 170
Ed Kind, past president, Chapter 170.

A.D. Alzheimer's Disease and Related Disorders Association, Inc.
17251 W. Twelve Mile Road • Suite 103 • Southfield, Michigan 48076 (313) 557-8277

Senator Donald Riegle's Hearing
on Health Care for Catastrophic
Illness and Long Term Care
Allen Park Municipal Bldg

July 27, 1987

TESTIMONY FROM:
Stella Robin
26811 Dover
Redford, Mich 48239
937-1169

Thank you for the opportunity to speak today. I am pleased that the Senate Finance Committee is considering this important issue of financial costs for chronically ill patients.

There is no question but that chronic illnesses, such as Alzheimer's and others, exact a high emotional and physical cost from the ill person, the family and the caretaker. These drains are often compounded by stress related to the high cost of caring for the ill family member. The cost is such that individuals frequently cannot afford it, or if they do, do so at the expense of their own ability to care for themselves and other family members. Costs of this magnitude are better covered by society at large.

My mother has been diagnosed as demented. She is still, however, at a point where I can manage her care at home. My ability to do so is quickly changing. At ages 70 and 72, my husband and I also have his parents to be concerned about. The only service that I have used to date for my mother has been senior day care. Unfortunately, three of the places that provide such service have closed down. She is now in a fourth day care center. Our retirement for which we so meticulously planned, has been non-existent so far.

The cost of the center is $100 per month. My mother also pays $100 per month towards food and other personal care. Her Social Security check, her sole source of income, is $497 per month. The remaining goes into her savings account. My mother's savings account is about $30,000. Most of that money is from the sale of her residence in Florida, which took place when it became apparent she could no longer manage by herself. My mother is in good health. Her needs are custodial, not medical. She needs help washing and toileting. She can feed and dress herself. When she goes into a nursing home, Medicare will not cover the cost. The savings will probably only last a little over one year. Nursing home care would probably be good for my mother. She likes being around more people. She needs constant watching and has wandered many times. Again, for two people in

their seventies, managing night and day care for someone in her nineties is difficult at best.

When my mother's savings are exhausted, will the nursing home accept Medicaid? I don't know. I know there are a number of homes that discharge people, or quietly move them into a hospital as a way of dumping them once they become eligible for Medicaid. It's illegal from what I understand, but there is not vigorous enforcement of that provision in Michigan or other places either, for that matter.

All of this brings home to me problems that my husband and I may also have, if one of us becomes seriously ill. Our savings, too, are modest. Our income is fixed and simply allows us to meet expenses. How will the non-nursing home patient of the two of us manage if all the savings or most of the income is directed to institutional care as Medicaid currently requires? All our effort to save for an enjoyable retirement will be in vain.

This Committee is looking at ways to help us and millions like us meet high financial burdens we face in caring for aged parents and spouses. Until now, the only solution has been for us to become poor. That's not fair. I urge you and your Committee to do something to help us now.

Thank you.

REGION III

Area Agency on Aging, Inc.

SPECIALISTS IN AGING

ROBERT L. DOLSEN
EXECUTIVE DIRECTOR

LYNN B. KELLOGG
ASSOCIATE DIRECTOR

August 20, 1987

Senator Donald Riegle, Jr.
716 Federal Building
110 Michigan Street
Grand Rapids, MI 49503

Dear Senator Riegle,

I want to thank you for the opportunity to speak at your hearing on catastrophic and long-term care that was held yesterday in Grand Rapids. As you indicated in your opening presentation, the out-of-pocket expenses for catastrophic and long-term care amount to $37 billion each year in the United States. Thirty billion dollars, or 81%, is spent on long-term care. As those who presented testimony so plainly demonstrated, assistance is desparately needed for those elders and their families struggling with chronic, debilitating conditions requiring long-term, custodial care.

After my testimony, one of your staff persons asked that I submit a copy of my testimony to your office. This is enclosed. Also enclosed is a copy of a presentation on "Catastrophic Health Care" made by Robert Dolsen in July, 1986. It explores in greater detail possible solutions to the long-term care problem.

I invite you and your staff to contact our office with any questions or comments you may have. Thank you for the attention that you are giving to this issue.

Sincerely,

Kris Petlick
Planner

KP/RL

Enclosures: 2

2919 DIVISION ST. • ST. JOSEPH, MICHIGAN 49085
1-616-983-0177 • 1-800-442-2803

STATEMENT OF THE

REGION IV AREA AGENCY ON AGING

Presented to

SENATOR DONALD RIEGLE, JR.

at the

PUBLIC HEARING ON

CATASTROPHIC AND LONG-TERM HEALTH CARE

Grand Rapids, Michigan

by

Kris Petlick

Planner

Region IV Area Agency on Aging

August 19, 1987

Senator Riegle, thank you for affording the opportunity to comment on the issues of catastrophic and long-term health care. I am Kris Petlick, from the Region IV Area Agency on Aging in St. Joseph, Michigan. Area Agencies on Aging are mandated under the Older Americans Act to "develop comprehensive, coordinated systems of services to help older persons stay in their own homes as long as possible." My comments today grow out of our agency's experience in working to fulfill that mandate.

Much confusion exists regarding catastrophic illness. To most older persons, "catastrophic" is represented not in acute illness or the recuperative period for that illness, but rather in the resultant inability to maintain their independence, the long stretch of dependence beyond recuperation when one feels he or she is a burden.

A typical example reveals this situation. A woman stricken with diabetes, partially blind with one leg amputated, is living with her husband who manages the home and gives her personal care. They own their own home and live on a modest income. She has suffered the trauma of surgery and the struggle of recuperation, and the medical costs have taken a substantial portion of their small savings account, but she has a loving husband, some personal autonomy, the dignity of financial independence, and her home.

One day her husband suffers sudden cardiac arrest and dies. With him goes practically everything. Her grief, she discovers, is only one of her problems. Not only may she lose part or all of his pension, but even more critically, she loses her support in activities of daily living. The costs for assistance to replace her husband's support far exceed her income. She learns that her most likely help will come in a nursing home. And the cost? a precipitous decline into poverty, involving the loss of her financial independence, her home, and a major share of control over her own affairs. This is her real catastrophe.

This phenomenon with minor variations is repeated daily across the nation, but the net result is the same, even among older persons who did everything right -- worked all their lives, saved their money, bought insurance. Their diligence and prudence are not enough.

It is important to underscore how devastatingly irreversible an institutionalized older person's condition becomes. Young people, poor and out-of-work, can hope to work again, to be financially independent, to own their own homes someday, to control their own lives. But an older person facing increasing disability without a helpmate must, upon "spending down" and entering a nursing home, abandon all hope to personal privacy and autonomy, and to the dignity of financial independence . . . virtually <u>forever</u>.

These unfortunate circumstances have been fostered, paradoxically, by the remarkable success of medical science, which has given us greater longevity. We are witnessing the rapid growth of the population over age 75. These are the elders most disposed to suffer chronic illnesses which debilitate.

As a nation we have not yet come to grips with the economic implications of our medical success. While there is a national commitment to curing acute illness and extending life, there is no accompanying commitment to assume the responsibility for the circumstances of that extended life.

Current public reimbursement mechanisms for elder health care are neither funded adequately nor structured appropriately to address long-term care needs. Both Medicare and Medicaid models are health models, and long-term care is primarily non-health-related. While short-term skilled nursing may be needed following medical intervention, those suffering long-term disability require primarily social support, such as personal care, homemaker services, home-delivered meals, chore services, and respite care.

A variety of options are being discussed and explored today that may prove to be viable solutions to the growing national problem of catastrophic and long-term care. Among the options are private long-term care insurance, Social Health Maintenance Organizations and Case Management. Most likely, a combination of strategies will prove to be most effective.

Another facet of long-term care is the care provided by the family. It is in-home care where family contributions are the greatest, some researchers suggesting as high as 80% of all care. Policy makers have proposed tax incentives to encourage even more family support. However, all evidence indicates that most families are already deeply committed to helping their troubled aged parents.

Funds for tax breaks would be more effectively spent on providing the formal services to support the families' efforts. A study by Brandeis University revealed that the longer families had to carry on without supplemental help, the sooner they wore themselves out, with the result that hospitals were increasingly forced to place aging parents in nursing homes. The problem is less one of providing incentives for greater family help than it is to provide desperately needed support for the existing family commitment.

Demographic projections indicate an 80% increase in needed nursing home beds by the year 2000 if policies remain unchanged. In the meantime, demand is growing, and policy makers must decide if home care will be a truly legitimate option or whether institutional care shall be the predominant setting for long-term care.

Thank you for your interest in the issue of catastrophic and long-term care. Legislative action is needed and most appreciated.

STATEMENT

OF

REGION FOUR AREA AGENCY ON AGING

ON

CATASTROPHIC HEALTH CARE

Presented to

PRIVATE/PUBLIC SECTOR ADVISORY COMMITTEE

ON CATASTROPHIC ILLNESS

in
Chicago, Illinois

by

Robert L. Dolsen
Executive Director
Region Four Area Agency on Aging, Inc.

July 30, 1986

Chairman Balog and other distinguished members of the Private/Public Sector Advisory Committee on Catastrophic Illness, thank you for affording the opportunity to comment on this growing crisis in America. I am Bob Dolsen, Executive Director of the Region IV Area Agency on Aging in St. Joseph, Michigan. Area Agencies on Aging are mandated under the Older Americans Act to "develop comprehensive, coordinated systems of services to help older persons stay in their own homes as long as possible." My comments today grow out of twelve years of experience in working to fulfill that mandate.

Much confusion exists regarding catastrophic illness. To most older persons catastrophe is represented not in acute illness or the recuperative period for that illness, but rather the consequences of the resulting inability to maintain one's independence because of disability, the long stretch of dependence beyond recuperation when one feels he or she is a burden.

A very typical example reveals this situation. A woman stricken with diabetes, partially blind with one leg amputated, is living with her husband who manages the home and gives her personal care. They own their own home and live on a modest income. She has suffered the trauma of surgery and the struggle of recuperation, and the medical costs have taken a substantial portion of their small savings account, but she has a loving husband, some personal autonomy, the dignity of financial

independence, and her home - all those valued things which give her life meaning.

One day her husband suffers sudden cardiac arrest and dies. And with him goes practically everything. Her grief, she discovers, is only one of her problems. Not only may she lose part or all of his pension, but even more critically, she loses her support in activities of daily living. The costs for assistance to replace her husband's support far exceed her income. She learns that her most likely help will come in a nursing home. And the cost? a precipitous decline into poverty, involving the loss of her financial independence, her home, and a major share of control over her own affairs --- the loss of those things which gave her life meaning. This is her real catastrophe. This is the spectre which strikes fear in the hearts of at-risk older persons.

This phenomenon with minor variations is repeated daily across the nation. The problem may be a broken hip, congestive heart failure, cancer, dementia, incontinence, arthritis, osteoporosis, but the net result is the same, even among older persons who did everything right --- worked all their lives, saved their money, bought insurance. Their diligence and prudence are not enough. Only the well-heeled are immune.

It is important to underscore how devastatingly irreversible

an institutionalized older person's condition becomes. Young people poor and out-of-work can hope to work again, to be financially independent, to own their own homes someday, to control their own lives. But an older person facing increasing disability without a helpmeet must, upon "spending down" and entering a nursing home, abandon all hopes to ever living in her own home again, abandon all hope to personal privacy and intimacy, abandon all hope to personal autonomy, and to the dignity of financial independence...forever.

These unfortunate circumstances have been fostered, paradoxically, by the remarkable success of medical science, which has given us greater longevity through stemming the rate of death from epidemics and cardio-vascular disease. We are witnessing the startling growth of the populations over ages 75 and 85, who, having survived many acute illnesses, are far more disposed to suffer chronic illnesses which debilitate.

As a nation we have not yet come to grips with the economic implications of our medical success. As Dr. Manning Feinleib, of the National Institutes of Health, states:

> "...if we eliminate or postpone the major causes of death by means of effective primary prevention (e.g., reduction of risk factors for coronary heart disease and stroke, elimination of environmental carcinogens) or better treatment of early stages of disease, it may not be cost-effective in terms of how it affects the total health care expenditure.

> In any discussion, therefore, we must be aware by the increased costs necessitated by higher morbidity rates in the elderly and this will prevail regardless of the methods used to provide health services.1

While there is a national commitment to curing acute illness and extending life, there is no concomitant commitment to assume the responsibility for the circumstances of that extended life. The awareness of the enormity of the problem is increasing, however. Dr. Alvin Tarlov, of the Pritzker School of Medicine at the University of Chicago, sees the issue this way:

> A new era is beginning wherein neither the prevention of death from epidemics nor the correction of physiologically measurable abnormalities will be the principal medical challenge. The central objective in the coming era will be the maintenance or improvement of individual patient functioning in the patient's normal environment while he or she performs usual activities.2

Yet the basic public reimbursement mechanisms for health care for the elderly are neither funded adequately nor structured appropriately to address long term care needs. Both Medicare and Medicaid models are health models, and long term care is primarily non-health-related, social support services. While there is following medical intervention a short period in which concentrated skilled nursing may be needed, those suffering disability require for the long haul primarily social support such as personal care, home maker services, home-delivered meals, minor home repair, chore services, counseling, and respite care. As Dr. Rosalie Kane of the Rand Corporation states,

> Both community and residential Long Term Care should not be viewed as health programs but as supportive human services to meet the needs caused by functional impairment.3

Since Medicare and Medicaid are not equipped to manage home-based long term care social services from several community providers, the Health Care Financing Administration has, with some justification, been reluctant to abandon the emphasis on institutional care, where fiscal control is more readily exercised. Instead they have looked to non-governmental sectors, such as private insurance and families, for help.

Private long term care insurance will unquestionably play a significant role in the development of a national long term care policy. It will enlist resources heretofore untapped for long term care and provide security for many older persons. The insurance industry should be encouraged to use all its creativity to design practical, affordable plans. It behooves public policy-makers, however, to scrutinize the limitations of private insurance and the ways the widespread introduction of private plans will change the nature of the nation's long term care system.

A typical policy on the market today requires an annual premium of nine hundred dollars for a couple of 65 years of age and provides up to three years of skilled nursing care or six

months of custodial care in a nursing home. (See Attachment 1.) Such a policy is actually very inadequate for long term care since most extended care is custodial, so we may anticipate increases in premiums to make the plans actuarily sound enough for public sale. It is very possible only about 20-25% of older persons will be willing and able to purchase adequate coverage. The lesson of Medicare can be instructive here. The growth of private health insurance following World War II drove health care costs and insurance premiums up rapidly, pricing a majority of non-poor elders out of the health care market. The consequence was the enactment of Medicare, the universal elder health care program patterned after the private cost-based, third party payer model.

If long term care private insurance similarly drives up costs and prices elders out of the market, the result could be a long term care system with two tiers of care, luxury care for private pay and austere care for public pay; or a political groundswell for a universal publicly-subsidized long term care program. It is highly improbable the majority of non-poor elders would accept a means-tested system.

Also, the private industry's penchant for indemnity policies reinforces institutional care, rather than the usually client-preferred, often less expensive home-based long term care, which encompasses vast differences in services and requires direct case-by-case oversight, the problem the Health Care Financing

Association has faced with Medicare. Demographic projections indicate an 80% increase in needed nursing home beds by the year 2000 if policies are unchanged. In the meantime pentup demand is growing, and policy makers must decide whether institutional care shall the predominant setting for long term care or home care will be a truly legitimate option.

It is through the development of the home care option that Area Agencies on Aging found themselves early on at the center of long term care issues. With Medicaid focused on nursing home care, the modest funds of the Older Americans Act have become the pre-eminent system for community-based long term home care for both Medicaid and non-Medicaid eligible older persons. Although our funds are very small relative to the billions involved in Medicare and Medicaid, our decade of experience has rendered a good deal of insight into the management of long term care systems, insight we would like to share with you.

Our client-oriented focus and our service-neutrality helped us see that in a competitive market system no third party reimbursement system which leaves the decisions for kinds of care, levels of care, and limits of care to the service providers without external controls can hope to manage the cost of, quality of, and access to long term care. And paper reviews have <u>very</u> limited value.

The problems of the functionally disabled elderly are most often multi-dimensional, and cannot be addressed adequately in the home by a single service provider system. Individual circumstances differ markedly, requiring varying degrees of health care, social support care, legal advice, psychological counseling, adaptation of the home environment, nutritional services, transportation, and chore services. They permit varying degrees of informal family support and demand varying degrees of professional participation. An inappropriate mix can be inordinately costly and unnecessary on the one hand, or dangerous to the older person's welfare on the other. In the increasingly competitive, deregulated health care system, with some providers survival-threatened and other aiming at market-dominance, the potential for both abuses is growing.

As Dr. Rosalie Kane of the Rand Corporation states:

> America's entrepreneurial ethic comes with a strong faith in competition and the free marketplace to keep the costs of the product down and the quality up.
>
> Competition in medical and social services yields duplication and gaps as providers compete for lucrative markets and leave others uncovered. And with a product as amorphous as long-term care, it is unrealistic to expect the consumer to fend for himself. When decisions are made at a time of crisis and the consumer is sick, the likelihood of careful shopping is even more remote. And a mistake is often irretrievable. If you purchase the wrong laundry soap, you know better next time. If you purchase the wrong long-term care, there rarely is a next time.[4]

Thus the most immediate and confusing task confronting an

older person with multiple, complex problems and her family is negotiating the increasingly competitive health care market. When a single local home health service provider operated a modestly funded project, there was little potential for abuse. But today competition is keen, and some providers turn on the hard sell for clients. Some providers have much professional integrity, but others are exploitive. In our region, home skilled nursing care costs range considerably. There are more and more of patients who receive care until the end of their Medicare eligibility, and then recover miraculously when funding runs out. And expensive health care is sometimes provided where much less expensive social support services or even trained family members would do.

This overutilization is a product of a poorly monitored and poorly managed system where frequency and duration of service for captive clients can be set by the providers who profit from the service. If I may paraphrase Parkinson's Law, "Client needs expand to fill the capacity of the service providers."

Aside from the appropriateness and extent of service, the cost of service in a third party payer system is a significant issue. Both Medicare and private insurance reimburse home health care on a cost basis, Medicare affording about fifty dollars for up to a two-hour session and private insurers even higher. The Region Four Area Agency on Aging can purchase the same service from the same agency using the same staff for less than twenty

dollars. (See Attachment 2.) As the director of the largest home health agency in our region said at a Congressional hearing in 1984: "A...difficulty with the Medicare system is that it has not encouraged cost containment, since it is a cost-based system. There is no advantage to the home health agency of remaining below the cost caps."5

Dr. Kane states:

> If there is to be competition and for-profit business in the care of people, there needs to be a guidance system to direct the competition and ensure that more money goes into care than is taken out in profits. The critical missing link in using competition productively is organizations that can assume both responsibility and authority for seeing that defined populations receive necessary care.6

One proposed link is the Social/Health Maintenance Orgnaization--or SHMO -- which has become a subject of some controversy in Washington, D.C. Designed and promoted at Brandeis University, the SHMO centralizes funding and service authority in a private agency which assumes total responsibility for acute care services and a comprehensive array of long term care services. Funding is made available on a per capita basis, which forces economy in service delivery. SHMO's are controversial since they tend to reshape entire community health and human service systems into a single consolidated system. They gain greatest acceptance in communities in which a single large service institution dominates.

An approach less intrusive is the Case Management (CM) approach, the mechanism toward which Area Agencies on Aging gravitated as we looked for ways to manage our funds more efficiently. Our client-focus and service-neutrality lent themselves well to the concept and the result has been a singular success. Combined with a mandatory pre-admission screening component and a service evaluation component, CM coordinates with discharge planning to broker services in a comprehensive continuity of care system without changing radically the local health and human service system. CM agencies usually control funds for services, but are most effective when they do not deliver hands-on services directly. Area Agencies on Aging have proved adept at handling Older Americans Act, Medicaid, Social Services Block Grant, and general funds through integrated case management projects.

Dr. Kane has stated that he fact that case managers do not profit from service delivery allows them to "be both advocates for the frail, vulnerable elders and husbanders of the communities' resources."7 Without such a guidance system, the unfettered ethic of the market place will overwhelm the passive, frail elderly. If Health Care Financing Association decides to launch into community-based long term care, it will have to adopt the SHMO and/or case management models in order to manage expenditures and services.

Policymakers are also looking to the families of functionally disabled older persons as a resource for long term care. One approach is to require adult children to share in the expenses of nursing home care. Not only is there considerable public resistance to the concept - witness the Idaho experience - but there are no solid precedents in American jurisprudence to help it survive a court challenge. Married persons freely enter into a legal bond, and parents bring children into the world through their own action. However, children are brought into families through no action of their own and make no legal commitment of reciprocity for their nurturing. Nor do parents rear children for the purpose of reciprocity of care. The obligation of adult children toward aged parents is moral and social, but not legal.8

Further, the advent of private insurance will diminish the moral obligation of the family. Unlike the public and non-for-profit sectors, which have traditionally used voluntary contributions, the for-profit sector is expected to perform its obligations in a businesslike way without supplemental voluntary charity.

It is in home care where family contributions are the greatest, some researchers suggesting as high as 80% of all care. Policymakers have proposed tax incentives to encourage even more

family support. However, all evidence indicates most families are already deeply committed to helping their troubled aged parents. It is unlikely tax credits will change behavior, but rather will subsidize family helpers for what they would do regardless.

Funds for tax breaks would be more effectively spent on providing the formal services to support the families' effort. Results of a study published in the Health Care Financing Review showed that "strains associated with financial assistance do appear of lesser consequence when compared to the social and emotional impact of caregiving on the family." (See Attachment 4.) While only 4% of interviewed families mentioned financial problems, 64% mentioned severe emotional strain, and 20% expressed a need for instumental assistance. A study by the Levinson Policy Institute at Brandeis University revealed that the longer families had to carry on without supplemental help, the sooner they wore themselves out, with the result that hospitals were increasingly forced to place aging parents in nursing homes. The problem is less one of providing incentives for greater family help than it is to provide desperately needed support for the existing family commitment.

Private long term care insurance is a fertile area to be cultivated in the long term care landscape. I am confident it will make a significant impact on the emerging crisis. I am not so confident that cultivating the families of aging parents will reap appreciable dividends.

The continued success of medical research, the consequent growth of the older-old population, and the current distribution of wealth lead me to conclude that, the roles of private sector and families notwithstanding, the public will continue to look to the public sector to meet the long term care crisis. The formulation of an integrated policy will necessarily include the restructuring of Medicare and Medicaid, a realignment of state and Federal responsibilities, a full review of health planning and the Certificate of Need process, and a redirection of publicly subsidized research in long term care - all issues too complex to explore in this short time. But the urgency of the issue grows and I wish you much success in your endeavors.

FOOTNOTES

1. Manning Feinleib, M.D., Dr. P.H.,, Proceedings of the Second Conference of the Epidemiology of Aging, Bethesda, Maryland, March 28-29, 1977, pp. 359-60.

2. Alvin R. Tarlov, M.D., "Shattuck Lecture - the Increasing Supply of Physicians, the Changing Structure of Health-Services System, and the Future Practice of Medicine," The New England Journal of Medicine, May 19, 1983, p. 1240.

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Depending upon the plan you select, you will receive benefits...

FOR HIGH LEVEL NURSING CARE, THE POLICY PAYS*

	PLAN A	PLAN B	PLAN C	PLAN D	PLAN E
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A Weekly Rate of...	$140	$210	$280	$350	$420
A Monthly Maximum of...	$600	$900	$1200	$1500	$800

*MAXIMUM OF THREE YEARS FOR ANY ONE CONFINEMENT

FOR CUSTODIAL CARE, POLICY PAYS**

A Daily Rate of...	$10	$15	$20	$25	$30
A Weekly Rate of...	$70	$105	$140	$175	$210
A Monthly Maximum of...	$300	$450	$600	$750	$900

**MAXIMUM OF 6 MONTHS OR 12 MONTHS FOR ANY ONE CONFINEMENT DEPENDING ON OPTION SELECTED.

The Maximum Lifetime Total Benefit					
with 6 months custodial care option...	$26,000	$39,000	$52,000	$65,000	$78,000
with 12 months custodial care option...	$28,000	$42,000	$56,000	$70,000	$84,000

OUR MOST FLEXIBLE PLAN EVER:

HIGH LEVEL NURSING CARE This policy can pay benefits for High Level nursing care beginning with the FIRST DAY and continuing for up to THREE YEARS.

CUSTODIAL CARE This policy will pay benefits for custodial care as described in the policy following a High Level nursing care confinement of at least 20 days.

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DEDUCTIBLE PERIOD Plans are available as follows: 0-day, 20-day or 100-day deductible. Rates vary according to your age and the deductible you select.

RECEIPT Check or Money Order Must Accompany Application

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AGENT— Check Plan Selected:

High Level Care Benefit Per Day

- ☐ $20 per day
- ☐ $30 per day
- ☐ $40 per day
- ☐ $50 per day
- ☒ $60 per day

Custodial Care

- ☒ 6 month
- ☐ 12 month

Deductible Period

- ☐ 0 day
- ☒ 20 day
- ☐ 100 day

Region IV Area Agency on Aging

Direct Purchase of Services Pool
FY '85 Status Report

Provider	Service	Current Area	Units-Wk	11-84 SBid	7-85 SBid	Current Match/Hr
1	HHA	Berrien &	80 +	8.50	7.25	0
	Hsk.	Van Buren	15	7.98	6.00	0
2	HHA	Berrien &	120	7.00	7.00	.75
	Hsk.	E. Cass	80	6.50	6.50	.75
3	HHA	Region	20	7.50	Not	N.A.
	Hsk.	Berrien	30	5.00	Available	N.A.
4	Hsk.	Berrien	120	7.15	N.A.	N.A.
5	Hsk.	Cass	10	15.00	15.00	.20
6	HHA	Cass	Open	16.26	16.26	0
	Hsk.	Cass	20	15.00	15.00	0
7	HHA	Region	300	7.45/8.4(N)	7.90/8.0	0
	Hsk.	Region	60	7.05/7.5(K)	7.35/7.4	0

This provider's rates are adjusted for travel over 30 miles from Benton Harbor for both services. Aide rates also increase if medication administration is involved ($9.00).

Social and economic incentives for family caregivers

by Amy Horowitz and Lois W. Shindelman

The recent emphasis on developing programs and policies to support families who care for aged relatives makes it important to understand the families' receptivity to the specific social and economic incentives under consideration.

The research reported in this paper draws on the experiences of 203 individualz identified as the primary caregiver to an aged frail relative currently receiving home care or day care services in New York City. As part of a larger study of caregiving behavior, respondents were asked to rank their preferences for various service and economic support programs.

Findings indicate that family caregivers perceive service and social supports, specifically medical care and homemaker service, as more crucial than both direct and indirect financial incentives. Furthermore, the issue of economic incentives elicited an extremely negative reaction from a significant minority who refused to consider such support in their personal family situations. The analysis indicated that the caregiver's background characteristics were not critical in differentiating caregivers who select either a service or an economic incentive. Among the set of variables defining the current caregiving situation, only sex of the aged relative and utilization of home care services were significantly related to choice of program. Respondents caring for females and high service utilizers were more likely to prefer service supports. Relevance of findings to current policy initiatives regarding financial incentives to families are presented.

Introduction

The dual concerns regarding escalating health care costs and the quality of care afforded aged Americans, has placed a primary emphasis on developing cost-effective approaches to meet the long-term care needs of the frail elderly in the community.

An interesting development in these policy discussions over the past several years has been the expansion of the target population to include not only the elderly, but their families as well. Government officials on both the Federal and State level are now considering the development of public programs and policies to support families caring for aged relatives.

This relatively recent emphasis on family-oriented services and incentives is based upon the growing body of knowledge regarding the role families play in providing care to the frail elderly. It has now been established that families are the predominant service and health care providers to the impaired elderly living in the community (Cantor, 1975; Hill, et al., 1970; Rosnow, 1967; Shanas, et al., 1968; Sussman, 1965; Townsend, 1965). Findings from a comprehensive study on cost comparisons of home care show that family and friends expend far more dollars than do agencies for maintaining elderly members at home and have been absorbing the largest portion of the cost compared to the expenditure of institutional dollars (U.S. General Accounting Office, 1977). Furthermore, the availability of a family support system consistently emerges as the primary factor in reducing the probability of institutionalization for the chronically ill aged person (Barney, 1977; Brody, 1966; Spark and Brody, 1970; Townsend, 1965; York, 1977).

Yet, the available evidence also indicates that relatives take on these responsibilities to the detriment of other responsibilities to self and family. They make extensive sacrifices in order to maintain their aged relatives in the community. Often these sacrifices can not be sustained indefinitely. Several studies have shown that the precipitator of institutional placement is more often exhaustion of family resources and excessive burden on family members than a change in the aged person's health status (Brody, 1966; Kraus, et al., 1976; Silverstone, 1978; Teresi, et al., 1978).

Furthermore, changing demographic trends promise to increase current pressures on families (Callahan, et al., 1980, Glick, 1979). Projections include an increase in the proportion of the most vulnerable segment of the elderly population, coupled with a decrease in family size. This is further complicated by an increase in the proportion of women who work and who are thus unavailable as full time caregivers to the elderly. All these trends will limit the ability of families to maintain aged relatives without support, regardless of their desire to do so.

These pressures on families, combined with those on the public purse due to the rising costs of institutional care, have led to the recent concern with developing programs which will encourage and support families to care for aged relatives.

At the current time, actual efforts in this direction are minimal. Service supports to families have largely been offered through local, small-scale programs with time-limited funding.[1] Efforts at direct financial payments to

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Reprint requests: Amy Horowitz, Brookdale Center on Aging of Hunter College, 425 East 25th St., New York, N.Y. 10010.

[1]An example of such a program is the Natural Supports Project of the Community Service Society of New York. This was a 3-year research demonstration program funded by the Administration on Aging to provide respite and support services to families caring for an aged relative. Program operation was limited to New York City area and only 96 families were served during the life of the project. Although the evaluators concluded that "services were strong incentives for families to resist nursing home placement," program operation was terminated at the end of the funding period (Frankfather, et al., 1981).

Summary and conclusions

In summary, this research examined preferences for social and economic supports among a sample of 203 family members currently providing care for a frail aged relative. The study found that overwhelming majority preferred service programs, primarily homemaking and medical care, to financial incentives. Furthermore, a significant minority refused to even consider economic supports in reference to their personal situation. The aged person's sex as well as current levels of service utilization were associated with a preference for service over economic supports.

These findings have direct relevance for upcoming policy decisions. On the most basic level, we must advocate that the preferences of potential recipients deserve to be taken into consideration in the formulation of public programs and policies. Evidence from both this study and that conducted by Sussman clearly indicates that those families who currently confront the reality of caring for an aged relative prefer service over economic incentives if they are faced with a choice.

Yet, most of the current debate, as well as initiatives regarding family support, have focused on providing financial incentives for family care. In attempting to understand why this is so, as well as why families appear to have contrary preferences, we must look at the assumptions underlying such proposals and the available evidence relative to these same assumptions.

The basic underlying assumption behind programs which offer financial assistance to families is that the latter are faced with economic constraints which limit their ability to maintain their aged relative at home. Cash incentives are assumed to remove these barriers and induce families to provide home care to a frail relative. However, all available evidence contradicts these assumptions. The most recent studies have consistently found that of all types of stresses inherent in providing assistance, financial hardship is the least frequently reported by caregiving relatives (Cancer Care Inc., 1973; Cantor, 1980; Frankfather, et al, 1981; Simos, 1973). Findings from other aspects of our study are consistent with this conclusion. For example, only 3 percent of our sample identified financial assistance as the most critical help offered the aged relative; whereas 61 percent and 20 percent chose emotional and instrumental assistance, respectively. This is not to say that caregiving does not involve financial help nor entail economic costs to the family. Excluding the 19 spouses in our sample, 43 percent of the remaining caregivers helped their aged relative financially, and one-fourth of the total sample said that their family's financial situation had changed for the worse since having assumed the caregiving role. However, the strains associated with financial assistance do appear to be of lesser consequence when compared to the social and emotional impact of caregiving on the family. When asked what were the major problems they faced, only 4 percent spontaneously mentioned financial problems, whereas 64 percent mentioned at least one problem having an emotional component. Furthermore, only 3 percent identified financial assistance as the most difficult caregiving task. In summary, the available evidence indicates that the financial aspects of caregiving are not perceived as the most stressful by family members.

Furthermore, there is little empirical support for assuming that cash payments would induce an otherwise reluctant family to share its home with an aged relative (Prager, 1978). The majority of families respond voluntarily to the needs of their aged members to the best of their capabilities. As Sussman, (1977) concludes, "[a]t best, incentives facilitate the process and make it easier for the already committed and do little to change the minds of the refusers." The use of the word "incentives" itself, is therefore, a misnomer. The terminology implies that, by offering such programs, families will behave in ways which they would not have in their absence. The target population of a program under this heading would be the minority of families who reject their caregiving role and the success of such a program would be questionable.

Programs as described in this article act not so much as enticements as they do act as supports which maximize and, hopefully, prolong family efforts. From the families point of view, service, rather than financial supports best meet this goal.

While the general argument advanced in this paper has been in favor of expanded social and health care services, as a final note, it must be clearly stated that we do not question that financial support would be of benefit to many families and that most families would not reject the support if offered. If this were the best of all possible worlds, we would be advocating that both economic and service supports be made available, but this is not the situation. Current budget constraints only promise to get worse and choices are inevitable when resources are limited.

STATEMENT JIM AUBLE, GRAND RAPIDS, MI

I am Jim Auble a senior citizen (age 73) living in N E Grand Rapids, Mi. I have been a member of the board of "Senior Neighbor's Inc" of Kent County, for 13 yrs. Have been on the advisory Council of the "West Lemoard Senior Center" for 12 yrs. A charter member of the "Senior Senate" of Kent County, a member of the""Michigan Senior Advocacy Council". During this perriod of service concerning the seniors in my State and County, I see a great need for Medicare Reform. This reform must provide Medicare coverage for benefits which are difficult and much to costly to obtain privately by many of our senior citizens.

Under Medicare Part A; the current $520 deductible per hospital stay should be limited to one deductible per year. The $130 per day for hospital stays exceeding 60 days and the $260 per day after 90 days are both a burden to the invalid senior. They should be eliminated, along with the lifetime days of coverage. Coverage should be as need for ones lifetime.

Under Medicare Part B; there is a need to limit the out of pocket expenses. I feel this limit should be in a range not to exceed a total of $1,000 for all deductibles annually.

Prescripton Drugs should not be a part of Medicare Part B; but should be the responsiblity of each state. Similar to what H B 4141 in the Michigan Legislature, (Senate Committee on Senior Citizens). A large number of the seniors now have this coverage under their pension and insurance plans, to add a basic premium for this would not be fair to these seniors. To give the responsiblity to the states to provide Prescription Drugs, would be the fairest way to supply this much needed service.

Spousal Impoverishment; is one of the high priority issues in any Medicare reform. Under the laws now in effect in most states a catastophic illness, will in the end result in both members of a marriage being forced to live on general assistance. As I understand the proposed resolution, a couple must spend down their assets to $12,000, limit the spousal income to $925 per month. This I feel is not safeguarding the spouse against impoverishment. I would like to see this

changed; at the time a spouse is declared to be suffering with a catastrophic illness, or declared to be terminally ill; a division of their liquid assets would be made giving each 50%; the surving spouse should also be able to keep the family home, and or principal residence, plus a car if they own one. This would insure the surviving spouse would not be forced to ask for public assistance, to live the rest of his or her life.

Under the Medicare reform proposed resolution; long-term nursing home care and cost is not addressed, but any reform must address must be a part of any Medicare reform. Private insurance for long-term nursing home care, is not affordable, at its present premium cost. To purchase this insurance will improvish a couple almost as rapidly, as a stay in a nursing home would. It is a simple fact that nursing home care (long-term) is going to be in the life of most seniors To give seniors the protection and care they are going to need long-term nursing home care must be a part of any Medicare reform.

Under H R 2470 seniors will be paying the drug bills for the general population with disabilities. This and utilization of Medicare fees to pay for the treatment of "AIDS" at an approximate cost of $10,000 per patient/ year, is not what Medicare reform should be about. I don't feel that "AIDS" is a great threat to the average senior.

The projected cost for Medicare reform under H R 2470, seems to be out of line for the older seniors; their benefits were set on a much lower income and or earning level; than the poeple coming into the program today. Many of the older seniors will be forced to drop part B coverage I feel, if the premiums are anywhere near the proposed levels.

STATEMENT OF PATRICIA E. BEVAK, LIVONIA, MI

I am a daughter of a parent that has Alzheimer's. After caring for my mother in her home for the last five years, with help from live-ins and Day Care Centers, it was necessary for us to put her in a nursing home. Believe me, it was a very difficult decision to make. Her condition had affected my Fathers health and after collasping in Church was rushed to the hospital where tests for the next five days were taken. After all this, he was given a clean bill of health, only to collapse once again just three weeks later in church. The emotional stress had taken its course, and he finally made the decision to have care for her outside the home. He still has many guilt feelings, and talks about bringing her home, finding other scorces such as day care homes or foster homes.

With one stress factor out of the way, another stress factor has arisen. That of financial care. When retiring five years ago at age 71, it had appeared that he had made some wise decisions in money matters for his retirement. With his Social Security and his investments through the Keough plan, he was self-employed, he felt that their retirement years would be well planned for.

My father receives $1020.00 from Social Security and $480.00 for my mother. His Keough plan gives him 854.00 monthly. A nice income that a retired couple could live on except when a dreaded disease with large medical cost occur that hospitalization insurance does not cover.

My mothers nursing home costs $1810.00 a month for an annual amount of $21,720.00. My fathers existing expenses for his home mortgage, insurance, ulities etc runs him $1500.00 a month for an annual amount of $18,000.00. This means that his annual investments along with Social Secuiry must be 40,000.00, and he is receiving $28,250.00. In order for him to keep her in the nursing home, it means that he must dip into their saving account for $12,000.00 per year.

How long will he be able to continue to do this will depend on his own health. Our elders still want their independence and do not want to be a burden to their children, however, what should happen if he becomes ill? What should have been happy Golden Years has not turned into a nightmare. My father at age 76 is talking about getting a part time job, and this is the Golden years!!

Alzheimers disease results in more than 100,000 deaths a year, placing this dreaded disease fourth behind heart disease, cancer and strokes. Within the next decade, one out of every 11 will be affected with this disease, however, little publicity is given this disease, and a large percentage of our population knows nothing about it.

Through modern medicine we are helping our elders live longer, however in public interest it is time that we help them live these last years with quality life. They need:

1. Long term care insurance policies.
2. Day Care centers
3. More respite help
4. Quality nursing homes.

It appalls me that insurance companies will not pay for any Alzheimer's care. It this is not a disease, then just what is it?

Locating a nursing home for your loved one is a very upsetting situation when they go into your finances asking just how long you will be able to afford to pay for their care, and then the share that you pay for private pay is higher than the states.

When paying 1800.00 a month for their care, I do feel that they are entitledto better care than what is being given today.

With more and more Alzheimer patients in nursing homes, I do feel that the personnel should be trained in caring for these patients. These patients do not need skilled care, but they do need supervision and things to keep them occupied so that they do not roam.

I get very angry finding my mother in restrains on visits and ask why and you are told she is roaming or we are short of staff. Was she violent? No! Do you call this quality care?

Separate wings in nursing homes, and staff that know how to keep them occupied is a top priority in my books.

This is not a easy job and the best scenario I can use is that of taking care of a toddler and teaching them how to put words together, how to recognize letters, help them find their favorite toy, teach them not to throw their food, and assist them to the bathroom. The only difference between the toddler and the Alsheimer patient is that the toddler eventually learns to do all these things, and the Alsheimers patient just gets progressive worse.

We have all been taken care of by parents, and now it is high time that we make our elders last years nothing but quality. If modern medicine can make them live longer, lets find ways to give them quality care.

Cass County Council on Aging, Inc.

130 N. BROADWAY ST. CASSOPOLIS, MI 49031 PHONE: (616) 445-8110 or 782-9389

CASS COUNTY COUNCIL ON AGING RESPONSE:
"CATASTROPHIC HEALTH CARE FOR SENIORS"

As an county-wide agency serving senior citizens, several areas of health care for the elderly cause serious concern.

One glaring deficit of the Medicare program is the lack of coverage to pay for prescription drugs, eyeglasses, hearing aids, and dental work. These items, particularly prescription drugs, are vital to the health of our senior citizens. This often represents a large portion of their monthly bills. Those whose income is too high for Medicaid but not high enough to pay all their bills find themselves going without necessary prescriptions. The inability to afford glasses, dentures, and hearing aids leads to withdrawal from hobbies, activities, and social isolation, beginning the vicious cycle of withdrawal, isolation, and confusion. One particular family in our county lives on approximately $780.00 a month. One spouse is bedridden, the other in poor health as well. Their Medicaid spend-down is $1,500.00 for a six month period. As Medicare does not cover prescriptions, this is their biggest problem. To date, they have spent $1,400.00 for prescriptions alone in the six month period. They have not been able to pay other bills. They have only three (3) weeks to go before they begin an entirely new $1,500.00 spend-down period. For this couple, lack of prescription coverage may mean the difference between living independently in their own home or placement in a nursing home to become Medicaid eligible. They are like many, striving desperately to help themselves and seek assistance only with expenses like this.

Medicare's denial of coverage for custodial care in nursing home treatment is another major problem for senior citizens. Spousal impoverishment due to Medicaid standards and regulations often leaves the spouse at home living in poverty as the income-producer receives medical assistance for nursing home stays. The spouse who does not produce the bulk of the income is left to run the homestead on a maximum protected level of only $374.00 a month. Spouses must choose to ruin their own health attempting to provide difficult and often inadequate care at home or place their spouse in a nursing home and live in proverty themselves, losing a home, that they may have worked their entire life for, due to inability to afford upkeep and maintenance. This is particularly disheartening for the families of Alzheimer's patients who may have provided exhausting care at home for a number of years, saving the government untold amounts of nursing home payments - only to find when they need help, none is offered.

It would be easy to say that private insurance companies may pick up the burden and solve the problem but their track record hardly supports this fanciful wish. Even in cases where custodial care is paid for, the prices are exorbitant, well beyond the means of the very people who may need it

most - ranging from $600.00 - $1,000.00 annually based on age. Many companies will not provide nursing home coverage if the consumer uses insulin, has Alzheimer's, rheumatoid arthritis, etc. - the very diseases that may make nursing home placement necessary.

Lack of Medicare coverage and Medicaid coverage for extensive in-home care insures inadequate health care for our older population. DRG's, despite the assurances, do result in much sicker, much frailer, patients being released much earlier from the hospital. Recently, our office assisted in bringing home an elderly gentleman, released from the hospital. He was so weak it required four people to assist him from the car, up the stairs, into his home. His inability to walk independently, cook, toilet himself, etc. required nearly round-the-clock assistance. This help was provided but the gentleman died a few days later. The fact he was able to obtain such assistance is the exception, the miracle. Most must make do with a weekly bath from the local Health Department and checks on blood pressure, medication, etc. every few days. While Medicare pays, in part, for this infrequent service, it ceases entirely after a given length of time because Medicare will not continue to pay for chronic conditions where no improvement is shown. The majority of the elderly needing home help care need consistent care for chronic conditions in order to remain at home. This in-home care, even with the addition of part-time or full-time daily personal, housekeeping, and medical assistance, would prove far more economical than nursing home care and certainly be the care preferred by our senior citizens.

The majority of our senior citizens have worked and struggled to pay their own way in our society. Their contributions have helped make our society what it is today. In a wealthy country like ours, it would seem that if billions of dollars can be sent to foreign lands for relief, equal amounts could be spent to take care of our own older population to provide the most basic of needs, access to proper health care. Now when these senior citizens are forced to ask for a helping hand to maintain their independence, we can not turn our backs.

Merri Terbargh

Merri Terborgh, M.A., C.S.W.
Program Coordinator

August 14, 1987

DEAF, HEARING & SPEECH CENTER *Senior Citizen Division*
26440 PURITAN AVENUE • REDFORD, MICHIGAN 48239 • PHONE 313 533-5443

June 27, 1987

TO: Donald W. Riegle, Jr.
(Senate Hearing on Health Care)

FROM: Emily Koss, Vice President

RE: Testimony related to nursing homes and subsidized housing where hearing impaired individuals reside.

The Deaf, Hearing & Speech Center is a non-profit organization providing supportive and clinical services to deafened and hard of hearing individuals. My primary responsibility within this agency is supervision of the Senior Citizen Division which serves most of southeast Michigan. This year, staff members and I have decided to focus on two issues which we've adopted as special projects:

1. The need for specialized services and education within the long-term care setting for both staff and deafened or severly hard of hearing residents.
2. The need for a barrier-free environment for deafened or hard of hearing tenants within subsidized governmental housing which includes senior citizen complexes.

The implications of hearing and/or speech loss within the long-term care setting are numerous but hinge on an environment, where frequently, the staff and hearing impaired resident(s) do not have an adequate means of communication. Without a satisfactory communication mode, staff members serving the hearing impaired resident can become frustrated and upset, at best, which might be reflected in the quality of care. Significantly, this issue has been recognized in the 1981, White House Conference on Aging Report on the Hearing Impaired People, as follows:

> "While fewer than 5% of the nation's elderly are in nursing homes, they number one million people. Professionals estimate that perhaps 90% of these people are hearing impaired. Some may be in nursing homes solely because of their hearing impairment.
> Staff in many institutions (nursing homes, hospitals, etc.) and social workers, psychologists, and rehabilitation counselors in general, often lack experience with hearing impaired persons. They may not differentiate between symptoms of senility and hearing impairment. More in-service training to change this situation is necessary".

As a result of poor communication and lack of quality care, many elderly, hearing impaired residents assume similar feelings that staff experience. Feelings of frustration, anger, disappointment, which are added to encounters of isolation and despair. Because of these traumatic experiences, these residents could and frequently do, succumb to withdrawal and indifference. This issue was recently explored in a current issue of SHHH (Self Help for the Hard of Hearing) magazine, where one author indicated:

> "A restricted environment such as an institution necessarily poses problems for such persons, not because the administrators do not care, but because a hearing impaired elderly person, often "retreats" into himself/herself, and perhaps rendered frail by other conditions, does not choose to, or cannot, explain his communication dilemma. Without adequate communication, a personality gradually withers and dies, for good mental health requires that a person be in touch with the environment and be able to receive and give ideas about what is occuring in that environment."

Increasingly, the Senior Citizen Division of the Deaf, Hearing & Speech Center has become aware of a number of deaf adults in nursing homes. The need for trained staff, who understand deafness has become imperative. Considerations on what to look for in placing a deafened individual within the long-term care setting is essential too. Most importantly, sign language interpreters need to be available occasionally, not only to tell the resident about special services they require, but to tell the spouse, who is bewildered and uninformed (because the partner is uninformed) about treatment plans, etc.

A collaborative effort is now underway between CBC (Citizens for Better Care) and our agency to discover and apply remedies to these continued problems. Joining me today is Carol Babb, a CBC intern and former volunteer with our agency. Carol will address these potential remedies and others in her testimony. It is the intent of those who are here to testify regarding the special needs of the older hearing impaired long-term care resident, to consolidate forces in the hope of alleviating some inherent problems and to request the support of the AAA (Area Agency on Aging) and the State Office on Services to the Aged in our endeavors.

Also, our agency is requesting further support with respect to a barrier-free environment for deafened tenants living in government subsidized housing which includes senior citizen residences. Presently, there is a national effort by deafened citizens to enforce "504 legislation" regarding such accessibility requirements as signalling doorbell devices and flashing smoke detectors. It is section 504 of the 1973 Federal Rehabilitation Act which stipulates:

> "recipients of federal funding are required to remove any communication, architectural, policy/practices or any other barriers that prevent handicappers from participating in, benefitting from, or being employed by such programs."

Yet, even with this law, facilities with hearing impaired residents are not barrier-free and said tenants, who meet minimal income guidelines, are expected to make their residences barrier-free at their own expense. The inconvenience, hazards, and expenses these tenants face is despicable and unfair because these dwellings are barrier-free to other handicapping conditions. Again, we wish for the AAA and State Office on Aging to join with us to emphasize the need for these basic items: doorbell signallers and flashing smoke detectors for hearing impaired tenants within governmental subsidized housing. When one realizes that 50-60% of individuals, age 65 or older, are experiencing hearing loss, of such severity that their daily communication is affected, the need for action is

obvious. When these statistics are imposed on the fact that Michigan ranks sixth in the number of profoundly deaf persons and seventh in the total number of hearing impaired population within this country, it becomes even clearer that action is necessary.

It must be remembered the hearing impaired population falls into a specialized categorical group within the state guidelines suggesting priority services to ---the socially and economically deprived. The responsibility for responding to communicative and environmental needs rests with all people who are concerned with the quality of life and basic human rights of others within the human family.

Thank you for this opportunity to submit comments and for your consideration.

STATEMENT OF ELAINE DONNELLY, LIVONIA, MI

Senator Riegle, I appreciate your calling this hearing today on ways to help families who faced with the burdens of catastrophic illness. I have a personal interest in this issue because of my father, Basil J. Chenevert, who is an extraordinary man who knows first hand about the pain and despair of catastrophic illness.

My parents still live in Lincoln Park, which is near here, but my father asked me to bring his statement to you because he is unable to attend in person. The reason is that in early 1979, my father was diagnosed as having amyotrophic lateral sclerosis, also known as Lou Gehrig's disease. A.L.S. is a cruel disease that slowly and relentlessly attacks the central nervous system and paralyzes the muscles of the body. The grim effects vary, but many A.L.S. patients quickly lose the ability to speak, as well as the ability to move. Progressive paralysis usually leads to dependence on a mechanical ventilator, or respirator, for the breath of life. At the present time, there is no cure.

A.L.S. does not affect the victim's mental abilities, however, which is a blessing. My father has used his undiminished intellect and power of imagination to figure out dozens of ingenious ways to cope with the physical ravages of Lou Gehrig's disease. Even though he is almost completely paralyzed at this time, he continues to enjoy a number of hobbies, and even manages to go sailing on his boat, respirator and all, when the weather is warm and the wind is right.

My father and all of us in the family thank God every day, not only because he has lived beyond the average predicted survival time for people with his ailment, but for the fact that this period of his life has been given comfort and meaning by a relatively new concept--the concept of home care--as an alternative to long-term hospital care.

Home care is a humane, cost-effective, and compassionate healer of patients and families when catastrophic illness strikes. In spite of my father's indomitable spirit and will to live, I don't know how he could have survived and lived such a full life, in spite of A.L.S., without the benefits of home care.

Dad asked me to speak to you today because he is all too aware of the fragile character of his own good fortune in having the benefit of 24 hour care at home. Were it not for an important decision that he and my mother made in 1978--a decision that seemed relatively unimportant at the time--there is no doubt that my father's financial resources and savings would have been wiped out long ago. If my father had not accepted his employer's offer to switch from conventional hospitalization coverage to a health maintenance organization (HMO) plan, one year before

he was diagnosed as having A.L.S., he would have had no alternative but to live his life out in the cold sterility of a hospital ward. That's the only kind of care that his conventional plan would have paid for. There is no question that any attempt to finance home care on his own would have quickly wiped out his financial resources, including the savings he intended to provide for my mother's future.

As my father has written in his monograph entitled Taking Hopelessness out of Helplessness, there are times when the concentration of medical skill, knowledge, and sophisticated life-saving equipment which hospitals offer is critical at certain stages of almost any serious illness. But when the patient is stabilized and recovery begins, the support of the family in familiar, non-institutional surroundings can actually accelerate recovery. This is especially true for children for whom separation from home is particularly traumatic.

Senator Riegle, I hope you will take the time to read about my father's valiant struggles against the ravages of A.L.S., as he has described them in the section of his monograph that I have copied for you. As his experiences demonstrate, with respect to terminally ill patients, when the prognosis cannot be changed, it is cruel to relegate the patient to continued hospital confinement. Since nursing homes usually refuse to accept patients whose lives depend on high-tech medical equipment like the respirator that my Dad uses, home care clearly becomes the only compassionate alternative.

Home care has given my father the freedom to make a number of changes that not only improved his health, but also allowed him to reduce the frustrations of complete dependency on others. The ALSSOAN magazine, Winter Edition, 1983 (copy attached) briefly tells the remarkable story of how he and his

doctors adapted a special trach tube that is both more comfortable and allows him to talk. Dad's monograph, which was dictated with some difficulty, includes the details on this story and descriptions of the dozens of ingenious inventions and procedures that he has devised to help control his home environment and enjoy life in spite of severe disability.

Dad reclines on a special chair that he designed to meet his needs for personal care with privacy, even though he is always in the center of activity in his own home. The chair can be wheeled out, lifted, transported in a station wagon, carried out on a boat dock, and suspended from a metal boom on my father's sailboat when he decides to go sailing, respirator and all.

I doubt that even Dennis Conner at the helm of Stars and Stripes enjoys a sail more than my father when he goes sailing with his family on the Second Wind.

Most importantly, Dad is free to enjoy continuous interaction with the family, and to be a part of countless family get-togethers and celebrations. He's been there to enjoy grandchildren ranging from infancy to college age, and he's been there to help all of us with good advice when we need it.

As my father wrote, "Long-term home care provides the comforts of life with those we love in a place most of us would choose above all others. To many A.L.S. patients, the difference between hospital care and home care is the difference between being kept alive, and being able to participate in life."

It hasn't been easy for my mother to cope with the challenges of home care, but the only thing worse would have been trying to cope without it. Our hearts go out to patients with catastrophic illness who have not been so fortunate. That's why I'm here today.

My family and I hope that when you are formulating legislation to deal the problems caused by acute and long-term catastrophic illness, you will keep in mind that the first and primary Department of Health and Human Services has always been the family. With reasonable financial help and/or flexible insurance plans, families can rally around to sustain a loved one when catastrophic illness strikes.

Please remember that the cost of home care is almost always far less than institutional care, as well as being healthier and more humane for the patient and family. The same kind of technology that helped to put men on the moon is being put to work to miniaturize the machinery used to sustain life. For example, the portable respirator that my father uses, which is small enough to fit under the seat of some wheelchair models, is the high-tech successor to the large and expensive iron lungs of yesterday.

- Please note that one major insurer, Aetna Life and Casualty, estimates that it saved $26 million in reimbursement costs last year as a result of home care. (Newsweek, "Staying Home, Feeling Better," July 7, 1986)

- Newsweek cites the case of one 12 year-old child with congenital abnormalities who (like my father) required a ventilator, a tracheotomy, and round-the-clock nursing. The daily cost of care for this child at home was $102.22, compared with $1,944.67 at the hospital.

- A recent survey done by the National Association for Home Care (NAHC) found that the average cost of care for a ventilator-dependent person in a hospital is $270,830 per year. In a home health setting, that same care drops to an astonishing $21,192 per year.

• In my father's case, the cost of semi-skilled medical aides plus life-support equipment and back-up systems comes to about $307.00 per day. If he were being cared for in a hospital, the cost would range between $1,000 per day for a non-emergency unit room, to $1,450 per day for an intensive care unit room. (Again, nursing homes generally do not accept ventilator-dependent patients.) In other words, my father's home care, which is far better and more humane for everyone concerned, costs about one-third as much as comparable hospital care.

I do not claim to be an expert on the Medicare/Medicaid system, the federal tax code, the many state laws affecting the health care industry, nor the many complicated federal and state bills being proposed right now to deal with acute and long-term catastrophic illness.

I am very concerned, however, about the thrust of several bills being considered by the Congress, including the bill that you have sponsored, Senator Riegle, which seem to imply that the government can and should be the health care provider of first resort. The fact is that the government cannot afford this burden, and I think it is a mistake to imply that it can.

The primary problem is, Senator Riegle, that the Medicare system is going bankrupt. No one wants to talk about it, especially in an election year, but the fact of the matter is that in 1986, Trustees of the Medicare system predicted bankruptcy for the Medicare Part A Hospital Insurance (HI) program in the 1990s under all but the most optimistic assumptions. (1986 Trustee Report)

Consider the voluntary Supplemental Medical Insurance (SMI) program, or Medicare Part B. This government operated insurance program for the elderly

was originally legislated to be funded half by premiums for the elderly and half by general revenues. But by 1985, political pressures and rising medical costs had already shifted the ratio from 50-50 to 75-25, with the taxpayers picking up over three-quarters of the costs.

The entire history of the Medicare program is not encouraging. The original cost was originally estimated to rise no higher than about $6 billion by 1980. The actual figure was $60 billion. In fact, since its inception in 1967, the entire Medicare program has suffered a 2000-fold increase in total government spending. Current Medicare outlays are increasing faster than defense outlays, at an average of 9% a year. In 1985 alone, over $72 billion was spent, and by 1992, annual Medicare expenditures will be over $100 billion. (Rep. D. French Slaughter, Jr. R-VA, "Health Care Savings Accounts: A Plan for Self-Reliance", The Heritage Foundation Lecture Series ISSN 0273-1155, 1986)

These are the reasons, Sen. Riegle, that I find claims that the Medicare extension plans currently being proposed—including your bill and the one that passed the House last week—will somehow remain "revenue neutral." In my opinion, these claims are about as convincing as Joe Isuzu's television commercials for Subaru, but not nearly as amusing.

It's no secret that long-term serious illnesses can cause catastrophic expenses. Even though most people believe that it just won't happen to them, over 70% of the elderly already have supplementary private insurance to fill the gaps in Medicare. There is a trend among private insurance companies to expand their medical plans and make them more flexible. Catastrophic illness legislation should encourage that trend, but by displacing the private insurance market that already exists, most bills I have read would do just the opposite.

Bills that raise expectations that cannot be met by the government are part of the problem, not the solution. Most of the catastrophic illness bills being promoted today would mislead and lull the American people into a false sense of security with regard to their medical coverage. A recent study by the American Association of Retired Persons (AARP) found that 80% of those surveyed believed that Medicare covers long-term care costs. In addition, some private Medigap policies mislead people with regard to the comprehensiveness of their coverage.

Instead of passing bills with "compassionate" sounding names that raise false expectations that cannot be met by the government, or that displace the private insurance market, I would rather see the adoption of more sound and realistic proposals to encourage the protection of people of all ages in the event that catastrophic illness strikes.

For example, appropriate tax benefits should be used to encourage individuals and self-employed people to buy comprehensive insurance plans to cover health services that extend beyond acute hospital care, including home care as prescribed and supervised by a doctor.

In the same way, appropriate tax benefits should be used to encourage employers to provide group insurance plans to cover health services that extend beyond acute hospital care, including home care as prescribed and supervised by a doctor.

Something must be done about insurance clauses that rule out home care, and innovative ways must be found to encourage individuals to save for medical expenses or to buy truly comprehensive private medical insurance that doesn't promise more than the company can deliver.

In the same way, Senator Riegle, you and other members of Congress who are concerned about catastrophic illness must stop promising more than the government can deliver. Some members of Congress may think it's good politics to promise the world to the desperately ill, while assuring the taxpayers that the program is "revenue neutral," but that is not going to solve the problem and the American people know it.

Although your bill and others do include modest increases in the number of days that would be covered for home care, such provisions would be of little help to patients suffering over a number of years from a terrible illness like Lou Gehrig's disease. The other problem is that the ultimate expense of inevitable cost overruns for your plan and similar bills would eventually fall on the Medicare system, which is already headed for bankruptcy.

Let's not kid ourselves--that is not the answer. There is no way that the government can shoulder the burden of all acute or long-term catastrophic illnesses, including nursing home care, unless future generations are saddled with catastrophic deficits and tax bills to match.

There are some proposals being talked about in Congress that would encourage comprehensive, competitive, reliable private insurance plans that are based on sound actuarial principles, and I hope you will consider supporting them. In the meantime, please don't forget the strength and willingness of America's families to care for their own. If, as the prayer says, God can grant us the serenity to accept the things we cannot change, the courage to change the things we can, and the wisdom to know the difference, all sorts of obstacles can be overcome. From our own personal experiences, my family knows that the effort is worth it.

* * * * * * *

Results of the Survey

Chronic Ventilator Dependent Individuals

Pertinent figures for cost comparisons

1. The total number of ventilator dependent individuals identified in the 21 reporting states is 2272.

2. The breakdown of these ventilator dependent individuals in these states, by age is:

19.3% are 17 or younger, ranging from 0 to 42.9%
51.0% are 18 to 64, ranging from 21.4% to 100%
29.6% are 65 or older, ranging from 0 to 70.4%

3. The mean cost to take care of these ventilator dependent individuals in the hospital is $742.00 per day, with a median of $730.00. This represents a mean cost of $270,830.00 per year per patient.

4. The mean cost to take care of these ventilator dependent individuals in the home is $1776.00 per month, with a median of $1191.50. This represents a mean cost of $21,132.00 per patient per year.

5. The total number of ventilator dependent individuals in 20 states (1992) who are deemed able to go home is 258. (Pennsylvania is excluded from this calculation.)

6. Generalizing to these states, from the estimate of costs for hospitalization versus home care, the relative savings would be $249,638.00 per individual, or $64,406,604.00 for all 258 identified individuals.

7. The proportion of ventilator dependent individuals who are deemed able to be sent home in each age group is:

16.8% of those 17 or younger
14.6% of those 18 to 64
16.5% of those 65 or older

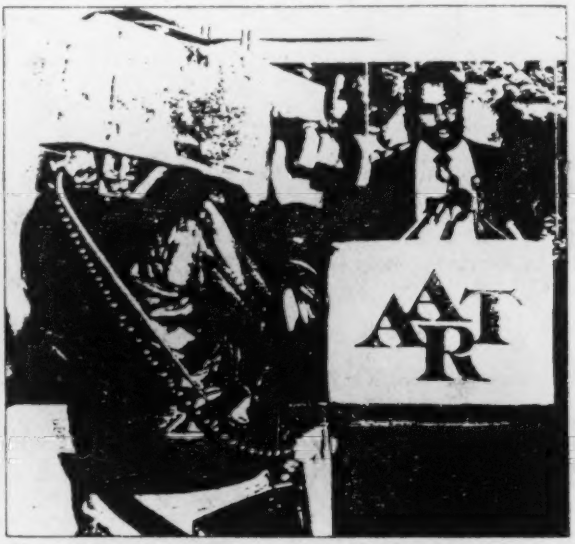
Notes on survey

** The total number of hospitals reporting information was 106. Of those hospitals, 96% were not for profit, and 4% are for profit institutions.

** Classifications of the number of patients deemed able to go home by population of the community in which the hospital is located is:

City Size

No. of patients deemed able to go home per hospital	25,000 or less (n=9)	25,000-50,000 (n=15)	50,000-100,000 (n=15)	100,001-250,000 (n=25)	250,000-500,000 (n=23)	500,001-3 million (n=19)
1	66.7	53.5	60.0	24.0	56.5	31.6
2-3	0	26.7	33.3	56.0	30.4	47.4
4-15	33.3	20.0	6.7	20.0	13.0	21.0
	100%	100%	100%	100%	100%	100%



RT director Dean Sterling describes the plight of three patients at his hospital who could benefit from a change in the rules. One family was turned down by Medicaid because they had money in a savings account — $800.

American Association of Respiratory Therapists' Magazine

ALSSOAN WINTER 1983

Patient Helps Design Own New Trach Tube

Basil J. Chenevert of ~~Livonia~~ Lincoln Park, Mich., diagnosed as having ALS four years ago, was told at one point that there was no tracheotomy (trach) tube available that would fit his physiology and allow him to talk while using a respirator.

"The cost of being unable to talk, especially with those I love, is the least bearable aspect for me of my illness," he said.

Chenevert, a retired mechanical engineer, wasn't willing to accept things as they seemed and, last spring, started working with his doctors and the staff at Henry Ford Hospital in Detroit to design a custom-made tube that would allow him to talk when the respirator is in use.

His efforts paid off and he hopes that others in similar situations will be able to benefit.

"My hope is that, if the type of trach tube that was specially designed for me is made universally available, other patients will be spared unnecessary discomfort and discouragement," he said.

Chenevert's daughter, Elaine Donnelly, says this is typical of her father's determination.

"My dad is greatly weakened by ALS but he still knows how to live life to its fullest in spite of obstacles that have stood in his way." she said.

As further evidence of her point, she tells of how her father was able to get out and enjoy the boat a number of times last summer.

This was accomplished by the construction of devices that wheel him out on the dock and lift him onto the boat in a lightweight, swinging chair which was suspended, while sailing, from the top of the boat's cabin.

According to Chenevert, his problems with the trach tube were principally of the persistence of his own body trying to heal itself.

"It was necessary to undergo at least six surgical re-cuts of my tracheostomy opening over a ten-month period before relief was found," he said. He went on to say, "Others, in a similar predicament, should know that a solution can be made available, even if an ill-fitting trach tube causes bleeding and repeat surgery."

Standard trach tubes, designed for use with a respirator, have a large, baggy inflatable cuff on the lower end which is inserted down into the windpipe. In Chenevert's case, the tracheostomy opening kept trying to heal and closed up, making it harder and more and more painful to insert the tube.

Chenevert hopes that doctors who treat patients with tracheostomies will encourage manufacturers to offer a larger variety of trach tubes with enlarged diameters on top, combined with smaller cuff sizes on the bottom as well as larger ones. He said that this would help to meet the needs of individual patients.

"My ability to talk is limited to spurts during the pressure part of the respirator cycle, but I find this to be a very acceptable alternative to complete silence," he said.

Staying Home, Feeling Better

An alternative to costly hospital stays is emerging

John P. Curran, 76, a retired Boston lawyer, is afflicted with a severe oversupply of iron in his blood—an anemic condition that usually requires hospitalization. But Curran spent two weeks learning how to administer 12-hour daily doses of desferal, a drug that rids his system of iron, by himself at home. He lays out the tape, syringe and "Graseby" pump—a tiny, battery-operated i.v. infusion pump the size of a Walkman—on his kitchen table every evening and gets the medication flowing into his blood through the night. When he has to attend a meeting of his men's club, he packs the pump into a special shoulder holster. This year he will even join his fellow members of the Ancient and Honorable Artillery Company on a vacation to Finland, carrying his i.v. kit with him.

Not very long ago, in the time of our grandfathers, most people rode out their ailments at home, in the care of relatives and the family doctor. It was only with the advances of 20th-century technology that hospitals began asserting their claim over our well-being. Now medical care is coming home again. Increasingly sophisticated technology, soaring hospital costs and pressure from insurance companies to discharge patients "quicker and sicker," as critics charge, are spurring the growth of an industry that is adding a new dimension to the way we treat illness. "Patients are happier at home," says Jean Preston, a director of the Boston VNA (Visiting Nurse Association). "They can sleep in their own beds, eat the food they like and feel in control of their own lives."

Complicated procedures. Home health means many things to many patients. Some hire aides to help with household chores and shopping errands. Others must turn to skilled nurses who oversee such complicated procedures as chemotherapy, kidney dialysis, blood transfusions and tube feedings in the patients' own living rooms. The savings can be substantial. "We're talking three home visits a week at $55 to $60 each versus $500 a week for a hospital bed alone," says Charlie Stutsman, director of development at the Atlanta, Ga., VNA.

Home care is a $14 billion-a-year business. More than 7,000 commercial agencies offer home-care services. Around half of the country's hospitals have gotten into the business, in the effort to stave off losses from increasing vacancy rates. Major companies like Avon and H&R Block are selling home health services through subsidiaries, and high-tech and medical-equipment firms are rushing to redesign products that were meant for hospitals. By now there is a versatile array of paraphernalia available for use at home: portable respirators and cardiac monitors, "lifeline" necklaces equipped with emergency alarm buttons and strap-on pumps for administering everything from nutrients to antibiotics to morphine.

Poor families. Elderly patients are the heaviest users of home-care services, but approximately one in four recipients is under 65. Among the younger patients, a growing number are newborn infants, many of them high-risk babies who need to be kept on home respirators, for example, or monitors for sleep apnea (a breathing disorder). St. Marys Hospital in Queens, N.Y., looks after chronically ill youngsters in their homes, providing nutritional counseling, occupational and speech therapy and medical monitoring for children with everything from burns to brain tumors. Most are from poor families eligible for Medicaid. Says program director Vivian Suarez, home health care is "an alternative to nothing. . . . To stay in a hospital would cost thousands."

Even chronically ill children benefit from home care. Bobby D. suffers from chronic secretory diarrhea, a condition that often keeps its victims hospitalized for the duration of their lives. But Bobby went home this past winter when he was two, with a feeding tube inserted in his heart. When he plays, his mother, Melissa, follows along with an i.v. pole and pump: 21 feet of tubing and his catheter. She keeps

High-tech self-help. *Feeding a toddler*
MA RYMAN

ack of the child's fluid intake and output and empties his catheter—a wearying routine, but preferable, she believes, to letting him spend the rest of his life in a hospital. "As soon as he came home, he was a happier baby," Melissa says. Indeed, Bobby has grown inches at home, picked up new words and learned to walk.

For an industry that has grown so dramatically, there is still a surprising lack of public awareness about home care. "It is largely an unknown product, understood only by a select group of social workers and doctors," says Steven Scheidt, director of marketing and communications for Beverly HomeHealth Services, one of the country's leading home-care providers. Part of the problem is that doctors themselves haven't kept up with the expansion of services; many simply don't know what is available out there.

Finding one's way through the thicket of specialized services, agencies and health workers involved in home care can be daunting. In major cities like Atlanta, for example, there are more than 50 organizations providing home health care. Hospitals often steer patients in the direction of agencies they have worked with and know to be reliable. Most are trustworthy, but "there is little quality control," warns Shelah Leader, of the American Association of Retired Persons. "It's a difficult industry to monitor, because the services are delivered in people's homes." Home-care associations report many complaints of abuses by unscrupulous agencies. Nonmedical home aides are low-paid workers, and some have been accused of stealing from their clients. "Some for-profit agencies are taking on more patients than they can handle, and the quality of care is going down," notes Boston VNA spokeswoman Leslie Leary.

Bus outlook. Even when the patient does find a reliable service, his worries are not over. Though home care is less costly than hospital care, the expenses pile up quickly. The issue of who foots the bill for home care has been hotly debated in Washington. Medicare picks up most of the tab for the elderly, but to qualify, a patient must need such specialized services as skilled nursing, physical therapy or speech therapy and must be able to show rapid improvement. In effect, this means that Medicare will not help pay for chronic, long-term illness—the bane of the health-care system. Despite the efforts of such powerful advocates as Sens. Orrin Hatch and Edward Kennedy and the verbal support of most members of Congress, the outlook for increased coverage remains dim. In the face of the burgeoning demand, government insurers are actually tightening up reviews of home-care reimbursement claims.

Louis Penland's father met the requirements of Medicare, but the going was still rough. His father was sent home from an Atlanta hospital after a week with a cancerlike condition with doctor's orders to receive hyperalimentation—a high-calorie, high-nutrition intravenous feeding. Penland had to pay $120 a day for a 12-hour nurse plus 20 percent of the $380 a day intravenous feeding. (Medicare covered the other 80 percent.) Moreover, an emergency developed one day when his father's main feeding tube slipped out. Luckily, Penland is a trained nurse and was able to handle the problem. For him home care was "stressful, expensive and risky."

For those ineligible for Medicare, private insurers are beginning to take up more of the burden. According to the Health Insurance Association of America, 81 percent of plans now provide home-care coverage, up from 5 percent a decade ago. A 1985 survey also showed that 9 of 10 Blue Cross-Blue Shield plans currently offer some coverage, and they are less restrictive than Medicare. Although they are so far paying for only about 10 percent of the overall national home-care bill, private insurers are among its most ardent supporters. One major insurer, Aetna Life and Casualty, estimates it saved $26 million in reimbursement costs last year as a result of home care. The company recently tracked 26 cases to determine cost savings for seriously ill children. In the case of one 12-year-old with congenital abnormalities who required a ventilator, a tracheotomy and round-the-clock nursing, the daily cost of care at home was only $102.22 compared with $1,944.6 at the hospital.

Cost cutting. As the nation's health expenditures wobble out of control, Washington keeps searching for new ways to cut costs. Sen. David Durenberger, chairman of the Senate subcommittee on health, says that while no new federal funds are likely to be made available for home care, something like a capitation or fixed-fee system, under which people could decide what kind of care they want, might emerge. Within such a system, he thinks, "we will see a lot of home health." The demand, in any case, will probably keep growing as the population ages and more people live long enough to encounter debilitating illnesses. Creating a manageable health system is one of the most formidable challenges facing the country, and home care seems a long stride in the right direction.

DAVID GELMAN with SHAWN DOHERTY in Boston, MARY HAGER in Washington, ANNE UNDERWOOD in Atlanta, MARIANA GOSNELL in New York and bureau reports

Carryout care: *Lawyer Curran holds his IV pump; patient wearing 'lifeline' necklace has her blood pressure taken in her living room by home-care aide*

BERNARD GOTFRYD—NEWSWEEK

AHA Data Project Moving Along

Speaking of collecting data, the AHA announced that it has received Medicare cost reports from more than 1,800 hospitals as part of its Medicare data independence project. The AHA intends to use the reports it collects to establish a Medicare cost data base independent of HCFA and will use the information during the congressional debates over the fiscal year 1987 Medicare budget. According to the AHA, the project has been endorsed by state hospital associations as well as several trade associations.

AY Compensation Survey Ready

Arthur Young's 1985-86 "Strategic Executive Compensation Survey for Multi-Facility Systems and Large Hospitals" is about ready for release. The survey reports on current compensation levels and practices among the larger trend-setting hospitals and health care systems with 500 beds or more. It is the only survey which examines the critical relationship between executive compensation and institutional financial and operating performance.

CEOs, CFOs and More Analyzed

Compensation levels are reported for 27 key executive and managerial positions such as chief executive officer, chief operating officer, chief financial officer, controller and several department head positions. Salaries are presented separately for single and multi-facilities as well as within bed-size categories.

COMMENT: The "Strategic Executive Compensation Survey for Multi-Facility Systems and Large Hospitals" is available for $375 for non-participating hospitals and $125 for participating hospitals. To order a copy, please write to Arthur Young, Human Resources Consulting Group, 100 Renaissance Center, Suite 2270, Detroit, MI 48243. Or contact Stacey Kaplan at (313) 259-4200.

LONG TERM CARE

Home Health Costs Analyzed

Home health care may be getting more attention in the months ahead if the results of a recent study by the National Association for Home Care (NAHC) reach the general public. According to NAHC, for example, the average cost of care for a ventilator-dependent person in a hospital is $270,830 per year. In a home health setting, that same care drops to an astonishing $21,192 per year. The study also noted that as many as 26 million patients may need home care right now, but only two million are receiving these services.

Home Care, Insurance Ranked High

In addition, the survey indicates that 72 percent of American favor home health care over nursing homes for patients needing frequent medical assistance and 65 percent support long-term care insurance. Survey respondents also indicated that home care has a positive image but is suffering from low visibility, particularly among the elderly and those on the lower end of the socioeconomic scale. This conclusion is somewhat disturbing, particularly since the two groups who could benefit most from home health care services know the least about them. Conditions certainly seem right for a major upswing in home health services, if public awareness increases.

From: Arthur Young Health Care Briefing Newsletter - 1986

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CATASTROPHIC ILLNESS AND COMPLACENCY

A Deadly Combination Threatening More Americans Than AIDS

Despite the flurry of attention focused on catastrophic illness by recent government proposals, my experience leads me to believe that its devastating effect has not been adequately defined, and that most midstream Americans are blissfully unaware that they can be the victims. We've all heard stories about elderly couples living on Social Security, forced to sell their homes to be eligible for Medicaid covered nursing home care. Since our middle class is the largest segment of our population, it's easy for most of us to sit back and think that this threat applies to others -- to those that don't have much to lose anyway. I believe people must be shocked into awareness that average affluence is no protection without proper health insurance and that long-term illness can drive most of us down to the Medicaid poverty level.

It is also time for Americans to learn the awful truth about their so-called "comprehensive" health insurance coverage -- namely, that it abandons them, using fine print restrictions, when they need it most -- for long term care. Furthermore, provisions for the most humane and cost effective health care management options such as home-based care are just as callously excluded from insurance liability. These facts greatly alter and ultimately shift the "interested parties" of the catastrophic illness controversy from government and the "less fortunate" to all of us who cannot claim independent wealth.

My own experience teaches that care for victims of Lou Gehrig's disease (ALS), polio, severe spinal injury, and other ailments involving paralysis or respirator dependency, can range from $120,000 to $360,000 per year. The cost of my care is currently at the low end of this range, because the staff of my hospital fortunately believed home care was feasible for quadriplegics on a respirator, and aggressively promoted this humane alternative. If I had been forced to remain institutionalized, the cost of my care would have been at the high end of the range, typically the only choice allowed by many less enlightened hospitals. Indeed, this is the only choice funded by many available health care insurance plans. About a year before I became ill, I made the most fortunate decision of my life when I switched from conventional hospitalization insurance to a new HMO. The key to this good fortune was that my new coverage did

not have the fine print exclusions against long term illness and home care that are common with most conventional policies.

It should be obvious that the half million dollars spent for my care during the last four years would have financially devastated all but the most affluent. It is also clear that current administration proposals limited to hospitalization care are deficient in many ways, particularly in failing to cover home care or, the final alternative for so many, nursing home care. I find it equally disturbing that fund management for this proposal is assigned to an already troubled "entitlement" program. I am sure the original framers designed the Social Security system to take some of the desperation out of the lives of low-income individuals who reach the end of wage earning power, with no resources to fall back on. I doubt that they visualized that this program would become an unwieldy political pork barrel, to be dipped into by anyone who has paid in the qualifying amount, for retirement checks that fail to distinguish between desperate poor oldsters and those who already have resources for a comfortable retirement. It will be demonstrated that the needs of both groups suffer under current administrative proposals.

The $2,000 deductible feature of the current proposal is in tune with this "entitlement" program mind set. It seems obvious that anyone who can afford to pay the deductible could also afford premiums for their own health care insurance. Others less fortunate will still be forced to sell their homes in order to spend down to the Medicaid poverty level if they are hit by long term illness. Reports also indicate that as many as 70% of the elderly have bought some form of Medigap Insurance. Even though most of these policies have clauses which limit the duration of coverage and have restrictions against nursing or home care, it seems particularly unwise to expand a government program to duplicate this coverage.

The rapidly declining ratio of contributing workers to retirement benefit recipients is the handwriting on the wall spelling out ultimate bankruptcy of the Social Security System if it remains unchanged. Adding adequate catastrophic illness coverage for the same broad segment of our population would only compound the problem. It will take a great deal of legislative courage to bite the bullet and return the Social Security system back to a basis of genuine need. This should include an extension of Medicaid coverage that will not force the

near poor to sell their homes. A delayed claim on the estates of these people would be more humane and minimize cost to the government.

While this approach means encouraging all others to purchase their own catastrophic illness insurance, it does not mean that the government can duck another obvious responsibility. Advertising by hospitalization and HMO private insurers, competing for health care dollars, should at least be subject to new government regulations that will eliminate deceptive and misleading claims. Too many people think they have bought comprehensive policies only to find that fine print clauses rule out coverage for long term or chronic illness, and payment for nursing or at-home care. Additional regulations are needed to protect against unilateral cancellation of coverage in employer-provided insurance plans. Tax incentives should also be granted for both individuals and employers to encourage purchase of truly comprehensive coverage.

Simple arithmetic shows that alternate proposals for I.R.A.-type health care plans are unrealistic. In an example given of a couple contributing $1,000 per year for 25 years, the fund would hardly cover the cost of two years of nursing home care. If the stricken member was lucky (?) enough to die before the money ran out, the survivor would be left with no coverage.

It is also dangerously foolhardy to be disarmed by claims that this plan could include clauses permitting withdrawals to purchase comprehensive health care insurance at any time. Catastrophic illness, such as Multiple Sclerosis, Muscular Dystrophy, severe spinal injury, and many other devastating ailments, can strike at any time and are not going to wait until you decide its time to buy proper insurance. It should also be obvious that the longer you wait the more you move into the high risk category that will make premium cost prohibitive. Indeed, medical conditions can develop that can make you completely uninsurable. In any case, funds committed to such health care savings plans would pass on to the heirs of those fortunate enough to avoid catastrophic medical costs. What a waste! Insurance premiums, on the other hand, contribute to a risk sharing pool that can lower insurance costs for all of us.

To return Social Security to a genuine need basis, individual I.R.A. investments must be encouraged and not dissipated by parallel health care savings plans.

While everyone except the very affluent is threatened by the possibility of catastrophic illness, it is also true that the majority will not suffer devastating long term illness. Accordingly, privately financed risk sharing insurance is the logical means of providing protection against this hazard for most of us. It seems ridiculous that almost everyone has life insurance and yet many fail to obtain protection from something that can be financially more devastating than the untimely death of a family member.

From a personally involved perspective, the most disappointing aspect of current proposals is the short-sighted failure to include provisions for home care. Whether funding is public or private, this humane alternative remains the best hope for controlling escalating medical costs. There still remains a vast resource of family caring that can be brought to bear on this problem. Supplementary professional help is still required to make home care practical in many cases.

The increase in sophistication of life support systems that extends our ability to keep people alive has also made it more difficult for families to handle home care unassisted, especially if primary care depends upon a frail marital partner. Although the amount required will vary from occasional visits by a nurse to 24-hour nursing assistance, I believe that my own case supported by information from my doctor, shows that this help can be provided at a fraction of the cost of similar institutional care.

I had to face my own mortality in early 1979, when tests revealed that a foot dragging problem was due to Amyotrophic Lateral Sclerosis, more commonly known as Lou Gehrig's Disease. Home care has had a dramatic impact on my current survival in several significant ways. Facing relentless progression toward immobility, hospitalization, and dependency upon life support machines had made me give up on whatever was left of life, and say "Let's get this over with as quickly as possible."

Shifting my care from the cold sterility of a hospital ward to the warmth of familiar surroundings gradually changed my depression and despair to hope and determination. Returning to limited participation in life with those who were most important to me, at a place I would choose above all others, made every day meaningful and worthwhile. I also found that these changes had a powerful therapeutic effect that reduced many of the medical problems I had been experiencing before I was sent home. These problems, unrelated and peripheral to ALS, had contributed significantly to the physical misery I felt at the time. Wonderous as it has been for me, my doctor assures me that home care can give comfort, life quality, and health improvement just as dramatic for a wide range of illnesses with prognoses not as dire as mine.

Unquestionably, the patient's access to the concentration of high level medical skill, knowledge, and sophisticated life-saving equipment which hospitals offer is critical at certain stages of almost any serious illness. Progressive hospitals now recognize that, when the patient is stabilized and recovery begins, that this recovery can be accelerated if the patient's recuperative power works with family support in familiar surroundings. This is especially true for child patients for whom being away from home is particularly traumatic. Doctors are also aware that, despite elaborate precautions, hospitals present a higher risk of a wide variety of dangerous infections than exist in average homes. With respect to terminally ill patients, progressive hospitals recognize that, when the end result can no longer be changed, it is cruel to relegate the patient to continued institutional confinement. I can testify that considerations related to the quality of whatever life remains to me loom much larger in my consciousness than easy access to medical skills.

Tracheotomies and portable respirators are a great improvement over iron lungs, but is was still a shock to realize that I would have to depend, in an ever increasing degree, on a machine in order to remain alive. I lost my appetite and must have been considerably less than the 120 pounds registered when they were able to balance me on the scale the last time.

Above all, it was the prospect of relentless progression toward immobility that made whatever seemed to be left of life completely meaningless. During this grim period, my spirits hit dirt bottom. At that time there was no certainty about whether home care would be feasible as my dependency on a respirator increased, and the question of whether home care would be covered by my health insurance had not yet been resolved. I needed anti-depressants and required pain killers and sleeping pills to avoid lying awake at night. As bad as things were, it seemed they could only get worse.

Fortunately, in my case, subsequent events proved that this early despair was unwarranted despite the fact that I am now completely unable to control any movement from the neck down, and I require 24-hour care by nurses' aides who work in our home. It was my good fortune that a progressive hospital was responsible for my care, and they encouraged and effectively promoted home care. They organized regular visits to my home by special nurses and therapists. They also engaged the services of home care agencies that provide and maintain special home care equipment and schedule nursing personnel for around-the-clock coverage.

The dramatic improvement in my physical condition and comfort includes the following: my appetite revived, and I am back to what I believe is over 150 pounds. I am also off the sleeping pills, anti-depressants, and pain killers. There is no question in my mind that home care is responsible for this marked improvement in my physical condition and attitude. I am living and still participating! The key factor that makes home care effective is the freedom and flexibility that it allows in my existence and treatment. No such leeway could have been allowed in a hospital where rigid procedures are dictated by specialization and a heightened awareness of malpractice vulnerability. Any hospital patient who has ever asked for an aspirin or gas pill becomes familiar with the bureaucratic inertia that must be moved to satisfy such a simple request. Heaven help that patient if his need develops near a shift change!

The ultimate freedom, of course, is the one which permits continued interaction with my wife and family; to be a part of family get-togethers and celebrations; to delight in the wonderful transition of our latest granddaughter from baby to toddler; and to enjoy her reaction to the birds and squirrels that take turns at the feeder box outside our livingroom window.

In view of today's skyrocketing medical costs, it seems inconceivable that the policies of many hospitals and health care insurance companies still bar use of the more economical and effective alternative of home care. These policies appear even more incomprehensible when humane considerations are given priority. Now we have catastrophic illness proposals with the same disregard for these vital considerations and related human misery.

In summation, there is a vast difference between being kept alive and being able to continue participation in life. General disregard for this difference all too often makes the legendary Eskimo practice of putting aged relatives out on the ice to die seem humane by comparison.

Although other approaches may succeed, it is clear that current catastrophic illness proposals fall far short of addressing realistic requirements. Common sense and my own experience indicate that a practical solution must include the following:

(1) Return the Social Security system to a basis of genuine need;

(2) Extend Medicaid coverage, so that people living on Social Security are not forced to sell their homes;

(3) Institute regulations to insure that truly comprehensive health care coverage is made available through private insurors; and

(4) Whether public or private, ensure that all programs include provisions for nursing home and at-home care.

There is an impelling need to make Americans aware that most of them are under the gun with respect to catastrophic illness. Without public awareness, it is foolish to expect that our legislators will ever treat this issue with more courage than lip service.

Evergreen Commons Senior Center
480 State Street • Holland, Michigan 49423
(616) 396-7100

August 12, 1987

The Honorable Donald W. Riegle, Jr.
United States Senate
Washington, D. C. 20510

Dear Senator Riegle:

My comments are offered to you from my perspective as Executive Director of Evergreen Commons Senior Center in Holland, Michigan. Through our Center over 5,200 members have access to 60 weekly leisure enrichment programs and activities, as well as the rehabilitative services of our Adult Day Care and the in-home services of our Advocacy office. Located in an increasingly developing industrial area in our state's fastest growing county, Evergreen Commons serves a socio-economically diverse population. Approximately one-third or around 1750 of our members live at or below the poverty level, and it is about those individuals that I would like to focus my remarks.

Few, if any, would argue that there currently exists an ever spreading crisis among our nation's low income elderly in meeting the rising costs of their own health care. We all know personally the dire financial straits imposed on someone experiencing either a single physical illness or steadily declining health over a long period of time. With the advance of medical technology has come understandable increased costs of rendering care. People are living longer due to this technology coupled with a heightened awareness of healthy life style habits. As one lives longer, the likelihood of his contracting an illness escalates. So, we can understand why it is that among our elderly, many of whom subsist on limited, fixed income, there exists a severe, if not impossible, financial burden in meeting the costs of their own or their spouse's medical treatment.

What, then, can we as a nation do to facilitate optimum care at affordable costs?

1. It would be my hope that in addressing the catastrophic health care costs of the elderly, any legislation would limit itself to just that concern. Let's not mingle the senior citizen's cost of care solution with that of any other minority, ethnic or age group. Those concerns, especially AIDS victims, should be addressed, but separately.

2. Assistance with prescription costs should be targeted to those seniors at or below 150 per cent of the poverty line, with a $240 annual deductible.

3. Alternative long term care options such as in-home nursing, Adult Day Care and Adult Intermediate Care Homes should be funded, at least in part, by Medicare and private insurers.

4. Long term care incentives should be established by allowing seniors to transfer their acquired IRA and life insurance assets tax free, if they purchase long-term care insurance.

5. Out of pocket expenses and/or Medicare should have a cap based on household income.

6. An across the board-Part B premium increase for Medicare participants would be preferable to any additional mandatory income tax to maintain Medicare solvency.

We must consider cautiously any long-term care funding and be realistic in its actual cost now and in the future. But we must also act swiftly to protect the life savings of so many seniors who are being forced into lives of poverty due to medical circumstances unpredictable in their early years.

Our rapidly increasing senior population deserves our financial support in averting financial ruin due to medical bills, and so I urge our Congress to draft effective health care legislation to safeguard the needy elderly in our society.

Respectfully,

Valerie Ambrose
Executive Director

VA:lek

STATEMENT OF MICHAEL L. HALE, GRAND RAPIDS, MI

Good Morning.

My name is Michael L. Hale. I am a resident of Grand Rapids, Michigan. I am a co-founder and past president of the Grand Rapids Area chapter of the Alzheimer's Disease and Related Disorders Association. I am also the son of a suspected Alzheimer's victim, and the grandson of a confirmed Alzheimer's victim. As some studies have reported that there may be a genetic link in some families with Alzheimer's Disease, I face the very real possibility that I also could be a victim of this devastating disease in ten, fifteen or twenty years.

My father was diagnosed as having Alzheimer's Disease in the autumn of 1981 (at age 62), and my grandmother was also diagnosed for Alzheimer's Disease shortly after that, although we suspected that something was wrong with both of them for some time prior to the diagnosis. My father was a practicing Dentist up to the day we had him admitted to Mercy Hospital in Muskegon for tests. Only through the process of elimination did his physician determine that he had Alzheimer's Disease. This, of course, is only a suspected diagnosis, as today there are only two ways to confirm a diagnosis of Alzheimer's Disease, one being a brain biopsy, the other being an autopsy following his death.

As much as I dearly love and miss my father's wonderful, loving and clever mind, I pray that he will die, so as to relieve the constant, daily grieving for the loss of his personality and intellect.

My dad has been a patient at Brookhaven Medical Care Facility in Muskegon since his diagnosis. As a family, my mother and I had no choice but to place him in the facility. Reason being that my mother is not physically able to care for him at home, and that my

sister is already dependent upon my mother for her constant care due to a traumatic brain injury from an automobile accident in April, 1968.

Prior to dad's diagnosis, my parents had some savings set aside for their retirement years. A sizeable portion of it had already been eaten away due to the medical expenses of my sister's accident in 1968, and triple bypass heart surgery for my dad in 1973. At the time of dad's admission to the nursing home, there was approximately $45,000.00 in various joint savings accounts, and Certificates of Deposit, only $5,000.00 of which was really my dad's. As we found out soon after his admission, his savings had been dwindling down as he used the money to keep his dental practice operating, despite only a few patients. Dad kept up the pretense of having a successful practice, and did not inform my mother of his financial affairs. This too, we realized later, was a result of the disease affecting his intellectual abilities. And, there were other signs, that we noticed only after discovering and understanding the symptoms of Alzheimer's Disease.

Since the money was all in joint accounts, we had to liquidate them to provide for the medical and living expenses of my dad, mother and sister. The Certificates of Deposit were cashed in early, resulting in substantial penalties. Now the medical bills had to be paid and the monthly expenses for nursing home care, totaling a minimum of $2,200.00 a month were begun to be paid, all from my parent's lifetime savings.

Fortunately, and sometimes unfortunately, my mother had her own small business to keep her busy. It really didn't pay a living wage, it was originally started to make some additional money that could be set aside for their retirement. Now that my dad was incapacitated, her business became her only income, and the only other source of funds to meet the medical expenses for dad.

Social Security was applied for in my dad's name, but the red tape involved really frustrated my mother, who had always depended upon my dad to take care of all the legal and financial details. Now, it became her problem. In less than one year following my dad's admission to Brookhaven Medical Care Facility, we (my mother and I) had to place my grandmother (my father's mother) into a nursing home in Muskegon, as she became too difficult to continue to manage in her own home, even with round-the-clock nursing care. Fortunately, there had been money set aside for her care by my grandfather, who passed away in 1968.

Let me pause here to state that my grandfather had planned for almost all eventualities, with the exception of dementia, when this trust was established. Now my mother and I knew that the bank trustees would cover my grandmother's expenses, as they had been doing for several years. But none of us were ever allowed by the trustees of the bank to have any indication of the amount of the trust fund monies. We were totally in the dark as to the amount of money available for the care of my grandmother. Thankfully, she passed away one year ago this month.

My mother faithfully continued to meet the expenses for the care of dad each and every month as their life savings soon dwindled to the legal level as determined by the Michigan Department of Social Services, before my dad's expenses would be picked up by the state. When that "magic mark" arrived, my mother began the long, involved, humiliating and embarrassing process to apply for state aid for dad's care. Finally, she thought, some help was going to arrive and she could now relax and focus in on caring for herself and her daughter (my sister). But it was six to nine months more before the state of Michigan would begin payments for his care.

During this time period, the state wanted to know the exact details of my parents finances. My mother obediently responded, but she was continually hassled by the local (Muskegon) office of D.S.S. for more details, because she apparently was hiding something. D.S.S. officials were certain that there was more money somewhere, and that my mother was not telling all. So determined were the D.S.S. officials, that they turned her case over to the Muskegon County Prosecutor for litigation. So hassled and humiliated was my mother by these "Pharisees", which is my charitable term for these uncaring and "I'm better than you" officials, that my mother said, **"They make you feel like dirt. They have no compassion for your situation"**.

My mother is a proud woman, preferring to do what she can to get by, without asking for anyone else's help. But, when she really needed the help, all she received was hassle, hassle, and more hassle, from uncaring bureaucrats who, without any basis, were determined that she was fraudulently deceiving them on her finances. And the paperwork necessary was endless. She was required to appear before them on numerous occasions, whenever the whim hit them, to provide more evidence of her financial status. **"Are you sure you don't have any more money somewhere?"** they continually asked. At each appearance, she was required to leave her business, her only source of income in the care of a family friend, because there wasn't enough money to have any employees. The only income from her business was $100.00 a week to meet the needs of both my mother and my dependent sister.

However, my sister did have nominal income from Suplemental Security Income (S.S.I.) and Social Security, since she is legally blind and dependent upon my mother for her care, as a result of the accident previously mentioned. Part of this money was given to mom by my sister as "room and board" to help provide for the two of them.

Finally, the state graciously began meeti. g the monthly expenses for my dad, but the hassles and the endless red tape continued. But once my grandmother died, and her will and trust passed on to my dad, that was it. The payments ceased from the state, and it became the responsibility of the bank trustees to care for dad's expenses. At the same time, the state quit hassling my mother, because they no longer had the responsibility of pay for my dad.

Incidentally, mom applied for Social Security at age 62 (1986) to help make ends meet. Now that D.S.S. is no longer involved in the case, and that the trust fund is now being drained, my mother is able to attempt to care for herself and my sister. As she put it, "**I survived (the D.S.S hassle and red tape) but it cost me my health. I just thought about surviving. Keeping my home and eating, not begging for welfare for myself and my daughter.**"

When I told her I would be sharing our family's story with you today, I also asked her for suggestions for you to consider in helping others in similar cases. She suggested that the system not be required to drain a couples financial resources, just to care for one of the partners. The System should be designed to assist people, not hassle and insult them. Have some COMPASSION.

In closing, I would like to state that if it had been possible to keep my dad at home, rather than in a nursing home, the costs would have been triple the current monthly bill for round-the-clock nursing care.

Thank you for listening, and I pray that you will take all the information you hear today and try to restore help, dignity, and compassion into the lives of all of us who are also victims, not of catastrophic illness, but who are victims of an uncaring and unconcerned system.

PCHA HERITAGE HOSPITAL UNIT OF PEOPLES COMMUNITY HOSPITAL AUTHORITY
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July 28, 1987

The Honorable Donald Riegle
The House of Representatives
Senate Office Building
Washington, D.C. 20510

Dear Senator Riegle:

Thank you for the opportunity to participate in Monday's Allen Park public hearing of the Senate Budget Committee. Your leadership in addressing health care issues is applauded.

Enclosed, a copy of the remarks I made.

Appreciation to your staff is expressed. They made me feel like a guest in my home base.

Sincerely yours,

H Arthur Sugarman
Administrator

HAS/sd
Enclosure

cc: Jack Owen, Executive Vice President
American Hospital Association

Spencer Johnson, President
Michigan Hospital Association

Senator Riegle, I speak on behalf of the health provider network from the view of a multi-hospital system; specifically, as a community general acute care asset.

Heritage Hospital, located in Taylor, Michigan, is a 281 bed facility of Peoples Community Hospital Authority, a health services organization serving Out-Wayne County and Eastern Washtenaw County. Hospital-sponsored services include home health care and a 70-bed in-patient Mental Health Unit. Catastrophic health care coverage is a major concern to community hospitals such as Heritage. Medicare eligible patients comprise about half of our general hospital census and about 90% of the home care patient count.

While the number of catastrophically ill patients at Heritage Hospital in a given month represents a small percentage, about 3% of our monthly census, 25 out of 835, resource consumption, financial and patient management impact is strongly disproportinate to this number. Impact is experienced most markedly in levels of cost of that care and effect upon patient, family and hospital quality of life.

My remarks are directed to three considerations:

Levels of Care; Financial Impact; Quality of Life Issues.

LEVELS OF CARE:

Problems associated with appropriate levels of patient care are experienced in both the general hospital and behavioral medicine services. First there is a gap in the continuum of patient care in access barriers for intermediate skilled nursing care facilities to which to discharge or assign patients. A typical example is the chronically ill patient with no family support who could receive care at home, but 24-hour non-skilled and pharmaceutical care are not covered by insurance unless delivered in a hospital. The hospital is defined and priced for acute care. Another example is the ventilator patient who stayed 448 days, because no skilled nursing facility could be found to accommodate her special needs. Her bill totaled $491,428, of which the hospital absorbed nearly $200,000.

Another ventilator patient had charges of $142,680 for over 60 days of hospitalization. Such problems could be helped by extending coverage to services other than inpatient, implementing the revised recommendations for home health coverage and skilled nursing services; alternatives to more expensive in-patient care. Extensions of coverage to include pharmeceuticals would also reduce financial stress of catastrophic illness.

FINANCIAL IMPACT:

Financial burdens caused within our health system relate to unpaid debts and cash flow; burdens to patients and to their hospitals and to other health provider resources.

A recent two month review of selected catastrophically ill ventilator patients provided the following information typical of our caseload. Length-of-stay for reviewed cases ranged from 30 to 448 days. Total billing during that period for 19 selected cases was $764,745.00 ($666,355 Medicaid patients, $98,390 Medicare patients). Total payments from Medicaid/Medicare were 15% of total billing. Medicaid ranged from 7% to 48% reimbursement of charges, Medicare ranged from 3% to 27% reimbursement of charges. Our hospital absorbed about 85% of total charges, or $650,033.00 for the two month term for this category of patients, catastrophically ill ventilator patients.

In addition, MPRO and private payor review of extended lengths-of-stay and related services may occur six months to one year after discharge. Results of such review may take another six months after a given catastrophically ill patient has been discharged, the hospital may be denied reimbursement and must compensate for those revenues which have already been included within long-term planning. An example is a 48 year old stroke patient who purchased private insurance, prior to having a stroke. Upon review, the insurance company decided that the patient had a pre-existing condition and refused payment for services. This patient weighed 300 lbs. and required a special bed. Post-discharge placement of the patient required an $8,000 purchase of bed by the family and approximately $2,500 per month to maintain the patient in a skilled care facility.

Denial statements are frequently vague or non-existent. Of 42 denials received by this Hospital in the last year, 69% either contained no reason for denial or did not reference which of several services had been the reason for denial. Most common response is, "unreasonable and unnecessary".

This ambiguity does two things. It may perpetuate the same mistakes or it may force hospitals to narrow the services they provide to catastrophically ill persons, consequently reducing the units of service and ironically creating the perception that these services are either of minimal consequence or not needed. In addition, ambiguous, unclear admitting diagnosis guidelines do not allow flexibility in treating all ailments with which a patient may enter the hospital.

QUALITY OF LIFE ISSUES:

Quality of life for patient and family or support network is a serious concern at Heritage Hospital. We see patients spend life savings prior to being discharged just to cover hospitalization costs. Patients who have limited private pay insurance, those who are uninsured or underinsured, must exhaust all resources before becoming eligible to receive Medicare/Medicaid coverage.

Forced into an inappropriate level of care because of coverage constraints which do not focus on the most independent, as well as least expensive level of care, patients lost control over the quality of their lives, self-esteem and capability for self-management, self-advocacy.

In conclusion, we strongly support recommendations made by the Michigan Hospital Association and the American Hospital Association. As a provider committed to a high quality of care, we seek specific and clear definition of service entitlement provided by catastrophic health care benefits coverage, and greater flexibility under DRG limits to move patients into the most independent, least expensive and most effective level of care for the individual's needs and resources.

Senator, to you, to your staff and our neighbors and patients, thank you for your attention and sensitivity. We anticipate success in these issues and the privilege to participate in your next health and human services agenda.

THE
INFORMATION CENTER, INC.

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Public Hearing: Catastrophic Health Care
Allen Park Civic Center
July 27, 1987

Hello, my name is Angelina Muscat and I am the Project Director for the Care Management Program administered by The Information Center in Wyandotte. Care Management provides assistance to senior citizens in the home in order to prevent an unnecessary move to a nursing home. We help people maintain their independence at home.

I would like to illustrate the need for long-term catastrophic health care with an actual situation.

Mr. E. is 85 years old and lives with his wife age 80. Mr. E. has prostate cancer, glaucoma, and is unable to eat solid foods. Over the years Mr. E. has gotten more disabled and cries easily. Mr. E. had been caring for his wife who is completely bed-bound with a fractured vertebrate and severe rheumatoid arthritis. Mr. E. gets some assistance from his daughter who lives near by.

The couples' combined income from social security is $785 a month. Over the years they have depleted their savings on medical expenses. Presently they pay for health insurance. In addition, they must pay for their prescriptions which cost more than $100 a month They also pay $200 a month in utility bills.

. For four weeks following a recent hospitalization, Medicare provided Mr. E with a nurse and personal care worker. Medicare payment was discontinued when he no longer required skilled nursing care. Mrs. E. has not seen a doctor since January as the last time an ambulance was needed to transport her to her doctors office and it was too expensive. Her doctor promised to make a home visit but hasn't.

Mr. and Mrs. E are now eligible for some assistance with housekeeping through the Michigan Department of Social Services, however they must pay the first $245 each month. They owe the drug store $600 in back medication charges. Together they are on 9 medications.

Nursing home placement has been strongly recommended for both Mr. and Mrs. E. While they are elibible for limited in-home assistance (i.e. houskeeping) Medicaid will pay over $3,000 a month for nursing home placement.

Simply put the cost of maintaining Mr. & Mrs. E. at home will cost half the amount required for placement in a nursing home. There are many other senior citizens in similar situations.

We at The Information Center, Care Management Program strongly suppport any effort to expand Medicare benefits to assist needy persons with chronic long-term illnesses and disabilities. Such assistance might include prescription payments, in-home nursing costs, in-home support including Care Management and finally, nursing home placements after all other avenues hawe been considered.

STATEMENT OF MARIE LATUVNIK, DEARBORN, MI

An Adult Day Care (ADC) program is defined as a structured program of health care and socialization which is designed to meet the needs of a population that, without intervention, is at high risk of institutionalization. It offers the participant professional supervision, observation and care in health, theraputic, restorative and nutritional services. In addition, the program offers planned educational, recreational and social activities. These services are provided in order to maintain the participant at his/her highest level of functioning, thereby delaying or preventing institutionalization.

The business of operating an ADC center to serve the poor elderly who would benefit from this service (but cannot pay for it) is very, very fragile. The last survey I knew about showed 26 ADCs in 12 counties in Michigan. New ones open and others close. Those who serve the poor are most vulnerable. Beside the heartbreak and trauma of the directors and staff for having to close, the real catastrophy lies with the clients and their families. Thirty to 100% of the clients are admitted into nursing homes within a year. Most on Medicaid.

A case in point. A couple of years ago the Center for Creative Living in Manistee, MI closed because the AAA had only enough money to fund either the ADC or In-home Services. They had to make a choice. The ADC lost out. The Center for Creative Living tried to continue with donations from the community and appeals to philantrophic agencies, but had to discontinue services. Within a year all 16 clients were in nursing homes, all on Medicaid. That ADC could have been kept open for the cost of 2 of those persons maintenence in the long term care setting.

What ever the reason for the ADCs closing, the results are the same. The hardship on the family or care givers becomes too great to continue and the Nursing Home industry has another candidate.

Case histories on ADCs closings can be gotten if needed. My point is, "serving the poor in this manner is a needed and a very fragile business". We, who work in this industry and care about it,have established high standards and guide lines for quality care, but, we are unable to make it grow. The most centers we have ever had was in 1984 when there were26. We lost 4 centers within this last year. More will open, but they never open in the same place and the dropped clients are lost.

For a business to survive, it has to have a stable source of income. Adult Day Care has proven itself as a cost effective method of caring for the elderly who cannot take full care of them selves. Most of the information traveling up the chain of command to our legislators speaks about the importance of Adult Day Care as an alternative or at least, the first step in the continuum of long term care. Yet, we cannot get their attention. Most of the information coming out of the legislative committees appears to ignore Adult Day Care as an inexpensive manner in handling a very serious problem

Adult Day Care needs a third party payment system to survive. We look to our legislators to find a way to help us.

MARY FREE BED HOSPITAL AND REHABILITATION CENTER
235 Wealthy St. S.E., Grand Rapids, MI 49503 Phone (616) 242-0300

August 11, 1987

Senator Riegle:

I am happy to be speaking to you today about my concerns about the lack of adequacy in the Medicare Health Coverage Program. Mary Free Bed Hospital and Rahabilitation Center is an 80 bed free standing rehabilitation facility in Grand Rapids, Michigan. It admits and treats patients with the diagnoses of CVA or stroke, spinal cord injury, head trauma, and has a pediatric wing. Patients come to Mary Free Bed after a stay in an acute care hospital. In other words, we are not the initial site of treatment after a medical incident or an accident.

Initial insurance coverages are used at the acute care hospital. Mary Free Bed quite often gets into more extended coverage. We note the following problems:

1) Many Medicare recipients do not elect to take Part B and do not have supplemental insurance coverage.
2) Ambulance coverage is inadequate.
3) The amount of home care is limited.
4) Where home care is granted, the recovery guidelines are those of a rehabilitation level which indicates a greater line of recovery. Often a patient is making progress and needs continued therapy to become independent in a home situation but the benefit does not last long enough to maximize recovery potential.
5) The amount of nursing home coverage is inadequate. Older persons who have suffered a trauma need sufficient time to become medically healed and then go through rehabilitation types of efforts. They do not necessarily recover as fast as a young person.
6) Medications are not covered. Supplies and medications can run to a great deal of money.

MARY FREE BED HOSPITAL AND REHABILITATION CENTER

7) The equipment provision is woefully inadequate. Only the most basic kind of wheelchair is allowed. Equipment which can make a lot of difference in terms of functioning at home is considered "safety" equipment and will not be funded. I'm speaking of items such as a transfer tub seat, raised toilet seat and versaframes. They minimize the risk of harm in the bathroom, are not costly and are not covered.

8) Even if a person has supplemental insurance, it only comes up to what Medicare screens allow.

You need not think that the stroke population is the only one which encompasses Medicare recipients. There are Medicare recipients in the closed head injury population and we have seen significant numbers in the spinal cord population, coming as a result of fall or accident.

Another consideration is that Mary Free Bed has only 80 beds and must weigh their admissions quite carefully. Our criteria for admission are medical rehabilitation goals and discharge planning. When we see an older person who does not have a significant other in the home to provide some care, and the coverage is Medicare only, we must very carefully assess how much care they will require and see if there is any way to achieve a discharge plan.

In spite of all these dark predictions, we are still sending 80% of our patients home, but we are forced to scrutinize those patients who receive rehabilitation services much more carefully.

Finally, you need to consider the needs of younger people who become catastrophically disabled. Those young people are not going to go back to work and may come on to the Social Security roles through the SSI system. Many of them have worked for some time, but there is no potential to return to work as they are permanently disabled. The insurance coverage and protection here is very, very inadequate. Equipment funding, and particularly home care and attendant care needs are not addressed by public insurances. We are forcing citizens into nursing homes who could live quite productive lives and certainly have better quality lives in their own home.

Thank you for the opportunity to come and make some remarks to you today.

Kate Lynn

STATEMENT OF REV JOSEPHINE MORGAN, COVERT TOWNSHIP,

VAN BUREN COUNTY, MI

MY NAME IS REV. JOSEPHINE MORGAN. I AM A RESIDENT OF COVERT TOWNSHIP VAN BUREN COUNTY. I WAS APPOINTED TO THE BOARD OF THE COMMISSION ON AGING, BY MY TOWNSHIP SUPERVISOR, IN 1975. I HAVE SERVED UNTIL THE PRESENT TIME.

I SERVED ON THE GOVERMENT TASK FORCE OF THE WHITE HOUSE CONFERENCE ON AGING IN 1980.

I AM SPEAKING FOR SENIOR CITIZENS FROM A RURAL AREA. IF YOU NEVER HAVE LIVED IN A RURAL AREA YOU WON'T UNDERSTAND HOW HARD IT IS TO GET THE NEWS AROUND. WE DO NOT HAVE ONE NEWSPAPER THAT COVERS THE ENTIRE VAN BUREN COUNTY.

SENIORS NEED HELP AND ASSISTANCE WITH MEDICAL PROBLEMS. I FOUND IN MY SURVEY THAT THERE WERE SENIORS WHO DIDN'T KNOW THE DIFFERENCE BETWEEN MEDICARE, MEDICAID, AND BLUE CROSS AND BLUE SHIELD.

THE QUESTIONS BEING ASKED WHERE "WHERE DO WE GO FOR HELP?"
WE NEED AGENCIES THAT CAN GIVE SOME DIRECT ANSWERS.

I FOUND SOME SENIORS WHO ARE USING THEIR FOOD MONEY FOR MEDICINE. I AM HOLDING IN MY HAND A RECEIPT THAT ONE PILL COST ONE DOLLAR. WE ARE NOT HERE COMPLAINING AGAINST HOSPITALS, DRUGGISTS, OR DOCTORS. WE FEEL THAT OUR GOVERNMENT SHOUND FIND A WAY TO ~~MAKE TO~~ GIVE OUR CITIZENS A WAY OUT FINANCIALLY.

WE NEED TO TRY AND STOP THE HIGH COST OF LIVING.

AFTER THIS MEETING WHERE DO WE GO FROM HERE?

WILL THERE BE ANYTHING DONE FOR SENIORS TO DO A FOLLOW UP?

WE WILL BE WAITING AND LISTENING FOR SOME ANSWERS.

WE WOULD LIKE TO THANK SENATOR REGAL FOR THE OPPORTUNITY TO EXPRESS OUR VIEWS.

State AMI

State Alliance for the Mentally Ill of Michigan

Affiliated with The National Alliance For The Mentally Ill

P.O. BOX 51102 (313) 425-1530 LIVONIA, MI. 48151

OFFICERS
President: Erma Barber
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WAYNE COUNTY
AMI Dearborn
AMI Downtown Detroit
AMI Eastside
AMI Southwest Family Support Group
Downriver AMI
Suburban West Support Group

TO: The Honorable Donald W. Riegle, Jr., U.S. Senate

FROM: State Alliance for the Mentally Ill of Michigan

DATE: July 27, 1987

SUBJECT: Catastrophic and other federal health care programs

I speak to you on behalf of the more than 1000 families among your constituents who are members of the State Alliance for the Mentally Ill of Michigan, a consumer support organization which is also a member of the National Alliance for the Mentally Ill. We have joined together to better communicate with our government on the the needs of mentally ill persons.

We know that this Congress is confronted by many proposals that are important to the well-being of mentally ill people. For us, nothing has greater importance than research into the causes and treatment of serious mental illnesses, particularly the NIMH Schizophrenia Initiative.

Serious mental illnesses like schizophrenia and manic-depression have a biological basis, just as diabetes, heart disease and cancer do. The recent discovery of a gene for manic-depression proves it; enlarged ventricles in the brain and diminished blood flow to the frontal areas of the brain are markers for schizophrenia; lab tests provide markers for brain diseases. Mental illnesses are treated with medicine and rehabilitation, and respond to treatment, like diabetes, heart disease and cancer do.

Mental diseases are devastating and costly to mentally ill persons and their families. Mental illness related deaths are estimated at 33,000, with suicide accounting for at least 29,000. The real number is thought to be much higher. Cost estimates for treatment, support and lost productivity are estimated at $106,200,000,000 yearly.

It is unjust and discriminatory to provide less health care coverage for mental diseases in catastrophic and federal health care programs than for other diseases. We ask you to support, at the least, the benefits provided in the House version of the Catastrophic Health Care Bill.

Members of the State Alliance for the Mentally Ill ask that:

1. Serious, mental diseases be given <u>equal treatment with other biologically based diseases</u> in catastrophic and other federal health care programs.

2. Federal health care programs for mental illness <u>be comprehensive,</u> covering both hospital care and community mental health care.

3. Catastrophic and other federal health programs <u>cover all mentally ill persons,</u> not just those qualifying for medicare.

4. <u>Research</u> funding for serious mental illnesses be greatly <u>increased</u>.

STATEMENT OF WESTLAND CONVALESCENT CENTER, WESTLAND, MI

Thank you for the opportunity to provide this testimony about a topic that deserves far more attention from those of us presenting and listening here today.

My testimony is based not only on the fact that I have been working in a nursing home for almost sixteen years, first as a registered nurse and for the past ten years as the administrator, but also upon my own personal experience with my grandmother who suffered from an Alzheimers related disease for seventeen years, fourteen of those years spent in a nursing home.

It was heartening to read the House passed a bill last week for catastrophic illness, until you read what was not in that bill. On Friday, July 24th, we were able to meet personally with Congressman William Ford at Westland Convalescent Center and discuss in detail for a few hours the effects and lack of effects of this bill. It is for certain that, once again, the long term ill elderly are left without a response from this government. It seems to me that a simpler place to start would have been with the 5% of the population over the age of sixty five who require long term care. You are very aware of the statistics and understand that the highest costs for health care are toward the end of a long life.

I would like to list the problems that we have identified. Many of these may sound familiar to you, but much more consideration must be placed on these issues:

1. The term "catastrophic illness" is misleading. What does it mean?
2. The extension of Medicare days from 100 to 150 for long term care is almost meaningless. The criteria established for classifying a patient as "skilled" is narrowing all the time. Most patients admitted to the nursing home use far less than the existing 100 days. Plus the fact that the last 80 days are covered by co-insurance. Nobody has gained anything with this extension as proposed in the House bill.
3. Most long term illnesses, such as Alzheimers, Stroke and others require more than what we now call "basic" nursing care. Most often, these patients require the most time and intervention by the health care team of professionals than any other.
4. The inequities in reimbursement from the acute care setting to the nursing home are staggering. We are expected, by the patient, family, physicians, other professionals, and our own philosophy to provide a continuum of care, at the same level, for a much lower rate. Which leads me to:

5. Benign neglect. Because of reimbursement, both medicare and medicaid, we are forced in the long term care industry to hire unskilled laborers who find, for the most part, their job in a nursing home to be stopover until they find a better paying job. If you had a choice: either stocking shelves at the newly opened department store, or even flipping hamburgers for that matter, or caring for people in their eighties, which meant bathing, feeding and cleaning excreta for the same rate of pay, which one do you think you would choose?

6. The catastrophe of long term illness is truly the devastating effect on the spouse, emotionally and financially. I have seen hundreds of families use every dollar on care because there is no other choice. The surviving spouse is virtually left penniless. We cannot just sit back and say these people got a raw deal. It could happen to any one of us, and will, to at least 5% of the people sitting in this room. I have also been asked on numerous occasions this question, "how can I get rid of mothers' money so she won't have to pay for her nursing home care?" You can imagine what I tell them. But, you know what, I bet they do figure something out, and those people are on medicaid.

7. Not taking a stand and dealing with the issues facing the long term care industry FIRST. Why do these patients have to take a back seat to hospital patients? Why are we so moved to regulate the long term care industry without providing a means to fulfill those voluminous regulations? Why is nursing home care supposed to come cheap? We have more expectations in the form of laws and rules to meet than any hospital could ever dream. Staffing requirements, for one, are nonexistent in the acute care setting.

With more and more individuals becoming affected by long term care these are some of the issues we must consider. Home health care and other services are providing seniors with more of an opportunity to remain in their home, but this will not effect the overall admission rate to the nursing home. With all the increased technology to prolong life no one is able to give us a quarantee on the quality of that life. As providers of care and lawmakers we must do everything in our means to improve the quality of that life.

The following are some recommendations we feel ought to be considered while deliberating this issue:

1. Little to no government involvement in the provision of options for funding long term care. Private industry has a tremendous capacity and the resources

to resolve this issue. Avoid having government get even bigger and bear the burden of this enormous task. You know the eventual outcome of too much government involvement, taxes and mismanaged business.

2. Improved rates for nursing home care to provide the incentive and where-with-all to meet the ever increasing demands placed on the industry.
3. Provide tax incentives for those who purchase long term care insurance.
4. Institute a condition of participation in the medicare program: all persons must have long term care insurance, rates being determined on a sliding scale basis.

The problems are many and the solutions difficult.

On behalf of Westland Convalescent Center we appreciate this opportunity and extend to you our assistance in providing feedback on issues as they develop.

Thank you.

Judith G. Caroselli

Westland Convalescent Center

36137 W. Warren

Westland, MI 48167

WEST MICHIGAN HEALTH SYSTEMS AGENCY

Testimony at Senator Don Riegle's Hearing
on Catastrophic Health Insurance
August 19, 1987
Grand Rapids, Michigan
Thomas H. Logan, Ph.D., AICP
Vice President for Planning

On behalf of the many volunteers, both consumers and providers, who make up the West Michigan Health Systems Agency, I want to thank you for the opportunity to comment on this very important issue concerning our health care system.

Our Agency has given a great deal of attention to questions of access to health care over the years. We have always found that consumers and providers are equally concerned about these issues, and our deliberations have always been positive and cooperative. Attached to my testimony today are recommendations from two studies: one is on long-term care alternatives completed last year; the other deals more directly with questions of financial access of interest in today's hearing--it is in draft form and will be discussed in an areawide conference on Access to Care in late September.

At this time I would like to make three summary points:

1) We still have a health care system which is prodigal in its habits. As we try to assure financial access to care, we must not just "throw money" at a faulty system. New initiatives must be designed to promote efficient use of any new resources which are put into the system.

2) Financial access to care is a problem, not just for some of the elderly, but also for a number of low-income groups in our society. We must make changes to plug the gaps in coverage for all of these groups over the next few years.

3) One of the biggest access needs of the older population is long-term care. As we address catastrophic costs, we must find ways of assuring both enough supply of supportive services and more adequate means of paying for them. The biggest lack currently is home and community services for people who would not need nursing home care, if they and their families had adequate support services. When nursing home care is the most appropriate service, we should have better public and private-sector programs of financing so that impoverishment is not the only option.

The attached materials give more detail on these points, and our office is always available to your staff on these and related issues.

Again, our thanks for the opportunity to present the results of our study and planning.

WMHSA
8/17/87
THL/ms

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WEST MICHIGAN HEALTH SYSTEMS AGENCY
LONG-TERM CARE ALTERNATIVES TASK FORCE

PROJECT OBJECTIVES

1. System Coordination

a. State adoption of a uniform patient assessment instrument.

ACTION: Communicate importance to the Legislature, State Departments, and other Michigan HSAs.
COMMITTEE: WMHSA Task Force.

b. Pilot test a coordinated long-term care management project.

(1) ACTION: Prepare and submit a funding proposal to the Kellogg Foundation.
COMMITTEE: Staff and WMHSA Planning Sections.

(2) ACTION: Give strong support to the proposal, in the community and with the Foundation.
COMMITTEE: WMHSA Task Force.

2. Volunteers

a. Reform the tort laws to cap non-economic awards for all types of liability, and to end the principle of joint and several liability.

ACTION: Communicate this position to the Legislature.
COMMITTEE: WMHSA Task Force.

b. Develop models for volunteer coordination and encouragement.

ACTION: Study existing volunteer systems within and outside of the area, and recommend improvements that could be made in area systems.
COMMITTEE: WMHSA Community Health Planning Section.

3. Day and Respite Care

Develop a strategy for getting more day and respite care services started by organizations in the area.

ACTION: Consult with various groups of providers, study the barriers to program operation, including state regulations, and recommend approaches for overcoming them.
COMMITTEE: WMHSA Physical Health and Mental Health/Mental Retardation Planning Sections.

4. Reimbursement

Increase the number of third-party payers and self-insured employers who will reimburse for day and respite care, Adult Foster Care (AFC), care management services, and home health aide services.

(1) ACTION: Communicate importance to the Legislature and Congress concerning Medicaid and Title XX services funding.
COMMITTEE: WMHSA Task Force

(2) ACTION: Communicate importance to insurance companies and to self-insured employers, seeking coverage of home and community-based services to the extent that extended care is covered if offered in institutions (e.g. nursing homes, rehabilitation hospitals).
COMMITTEE: WMHSA Insurance Advisory Group and Task Force.

5. Education

Educate policy-makers on the need for more, and for more efficiently and effectively used, resources for long-term care.

ACTION: Develop an educational package to reach both policy-makers and the public.
COMMITTEE: WMHSA Health Forums.

Adopted by the Task Force on May 14, 1986.

WMHSA
TL/ms
6/4/86

DRAFT
5/8/87

"Excerpts From"

ACCESS TO HEALTH CARE

WEST MICHIGAN HEALTH SYSTEMS AGENCY
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ACKNOWLEDGMENT

Members of the Ad Hoc Committee on Access to Care who shared their experience and expertise in developing this report were:

Co-Chairpeople
-Gary Gershon, Executive Director, Michigan Migrant Legal Assistance
-Robert McKown, Assistant State LTC Ombudsman, Citizens for Better Care

Judy Brown, Continuing Care Coordinator, Blodgett Memorial Medical Center

-Donna Lee Fabian, Director of Nursing, Nurses Unlimited, Inc.

-Kathy Higgins, Administrative Assistant, Luther Village Community

-Jean Kingshott, Director of Nursing, Lakeshore Community Hospital

-Calvin Mulder, Sr. Vice President, Butterworth Hospital

-Rosanne Richards, Executive Director, Region 14 Council on Aging

-Jeffrey Schilling, Assistant Executive Director, Hospital Council

-Steve Smith, Executive Vice President, Sparta Health Center

-Jeffery L. Welch, Administrator, Oakview Medical Care Facility

-Larry Yachcik, Administrator, Lowell Medical Care Facility

Staff
-Craig G Nobbelin, Health Planner

I. SUMMARY

This study confirms the observations among providers and advocacy groups that access to health care is getting worse among vulnerable groups of people, including the uninsured, the poor, the near-poor and the elderly. In an effort to stem this trend, consensus was reached on a variety of policy positions for changes in the health care system which could contribute to better access. These policy directions include:

- -assuring access is the responsibility of both the public and private sectors;
- -changes in public financial assistance programs, perhaps major ones, are needed to assure access and plug holes in the governments' "safety net";
- -systems of community-wide, uniform patient assessment and case (care) management can help to assure appropriate placement and improved access;
- -encouragement and incentives are needed to promote use of community support services;
- -access to appropriate care should not be denied on the basis of patient characteristics;
- -changes in Michigan law and regulations can contribute to better access to nursing homes;
- -more educational outreach programs on available health care services and programs on available are needed;
- -independent patient advocacy and legal assistance groups can contribute to improved access;
- -some cost savings achieved by all parties should be directed toward charity care;
- -more standardization and coordination among third party payers should improve access.

Table C presents health insurance coverage estimates for various population characteristics. The data presented probably underestimate the degree of problems since some who have insurance for at least part of the year may be without it during other parts of the year and the insurance coverage which some people have is inadequate. Caution in interpreting the data should be used since the impact of the Consolidated Omnibus Budget Reconciliation Act (COBRA) (effective July 1, 1986) could affect the percentages of uninsured in some way. The impact will probably not be known for at least a year or two. Almost 89% (933,425) of the population is estimated to be covered by some type of health insurance. Just over 25% (188,554) had public-only coverage or a combination of public and private coverage. People without any coverage account for 11.4% (127,822) of the total population.

The percentage of uninsured people is practically the same in both the working (11.3%) and non-working (11.5%) groups of the population. Logically, more working people are covered by private insurance (81.5%) while non-working people rely more on public programs or a combination of public and private programs.

Insurance coverage varies noticeably among age groups. People 20-24 years old are most likely to be uninsured (27.5%) while those over 65 years are least likely to be uninsured (0.5%). At least a third (33.2%) of those over 65 years who only have public insurance (Medicare or Medicaid) have inadequate coverage because of the coverage gaps in those programs. A higher level of public and privately public coverage (22.7%).in the youngest age group (0-19) than in other age groups under age 65 years reflects participation in the Medicaid program.

Non-whites are somewhat more likely to be uninsured (16.8%) than whites (10.6%). In absolute numbers, almost 8 times as many white people (110,184) are uninsured as are non-white people (13,738). Private coverage is greater for whites than for non-whites (67.2% versus 42.2%) while public insurance coverage is more common among non-whites (36.8%) than for whites (11.3%).

Differences in coverage between the sexes is slight, with a slightly higher proportion of females having at least some public coverage (26.4% compared 22.6% for males) and more males being uninsured (12.2% compared 10.7% for females).

B. Policy Issues

The policies developed by the Ad Hoc Committee on Access to Care are presented according to the applicable categories found in the Health Systems Plan for West Central Michigan (HSP). Existing goals and policies which have been reaffirmed are identified with the HSP letter and number. New sections, goals and policies are so identified. Discussion follows each of these in an attempt to give background or clarify the intent of the statements.

PUBLIC ASSISTANCE PROGRAMS

New Goal G.4. Public financing programs to help people gain access to needed health services serve vulnerable people in society and operate in an efficient and effective way.

All people have a right to expect reasonable access to health care services throughout our country and region. With this access, they have a right to expect quality services rendered in a humane and cost effective manner. However, throughout history, people have not had reasonable nor equal access to health care. From the almshouses for the poor, the institutions for the mentally ill and the hospitals for the sick in the eighteenth century, the poor and disadvantaged in our society have received separate and unequal care. Although it is true that charity has played a role in providing care for some of those who needed it, the impact was limited.

With several congressional actions in this century, our society initiated a strong commitment to attainment of equal access to health care for all people. These included the:

-Social Security Act of 1935
-Hill-Burton Act of 1947
-Community Mental Health Centers Construction Act of 1963
-Social Security Act Amendments of 1965 - Title 18 (Medicare) and Title 19 (Medicaid)
-Rehabilitation Act of 1973
-Health Planning and Resources Development Act of 1975

Without good health, the opportunities elsewhere in life for individual accomplishments and quality of life are denied.

In the 1960s when the two major health care financing programs, Medicare and Medicaid, began, there was an assumption that adequate resources existed to assure access to care for all people in America. Spiraling health care inflation took hold in the 1970s and the resource limitations became apparent as health care costs grew from 6% of the Gross National Product (GNP)in the mid 1960s to 9.8% of GNP by 1981. By 1985, it had risen to 10.7% of GNP. Cost increases and an apparent retreat from programs designed to improve access threaten the progress which has been made. Emphasis on "competitive forces", tightening eligibility requirements and possible cost sharing ideas have great potential to increase the inequities in access that continue to exist. In contrast to these threats, a 1983 Presidential Commission stated that "society has a moral obligation to ensure that everyone has access to adequate care without being subject to excessive burdens" (President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, 1983). All of this activity suggests that the goal of equal access for vulnerable people should continue to be pursued and that government has an important role to play in reaching it. It also suggests that refinements or more major changes in the current system may be necessary to make more efficient and effective use of resources in the pursuit of the goal. The policies under this goal describe directions which should be considered as the public financing programs relating to health are analyzed and improved.

New Policy G.4.1. The Federal government should overhaul the Medicare system in order to make it more understandable and simpler to use by those eligible for its coverage. Elements which should be considered in the overhaul should include but not be limited to:

-merging Parts A (hospital care) and Part B (doctor care) while maintaining contributions from participants based on ability to pay;
-requiring provider acceptance of Medicare payment as payment in full;
-eliminating regulatory and eligibility barriers which effectively discourage use of home health and alternative forms of community-based services (see also Policy H.2.1.);
-establishing Medicare as a primary source for reimbursement of nursing home care, in coordination with other third party reimbursement programs;
-coordinating Medicare benefits with catastrophic insurance program(s) developed (see also P.5.5.);
-developing an educational package to clearly explain the benefits, services covered and the claims process.

Medicare has become a complex maze both for consumers who try to use it and for health care providers who accept Medicare reimbursement. The Medicare program is confusing for most people when they try to understand who pays for what part of their health care costs, with Part A, Part B, private supplemental insurance, supplemental billings by providers who do not accept Medicare payment in full, and so forth. Added to this are complex eligibility requirements which frequently eliminate coverage for needed care because a series of technical requirements have not been met; for instance, hospitalization for at least three days before nursing home or home skilled care will be reimbursed. And, then, it is a shock when people find out that Medicare does not effectively cover much long-term care, but only some nursing home care, some home health care, physician services and a few other health care costs.

Some of the changes would simplify the process and thereby actually lower costs, possibly even with an expansion of benefits. Medicare is perceived by the elderly as covering most of their health care costs. Long-term care, including nursing home care, home health care and other supportive care, should be considered for more complete inclusion under Medicare. This could have a vast impact since at least half of the people over age 65 years will need nursing home care at some time in their lives. From the consumer's perspective, an overhaul of the Medicare program is a realistic and more productive alternative to the current system. Now, individuals or couples have to spend all their resources from a lifetime of work down to the poverty-level before they become eligible for assistance through the Medicaid program. This type of major overhaul should also include the concept of catastrophic health care coverage and the development of long-term care insurance. Even with consideration that limited Federal funds can be allocated to health care, it is time to reassess the structure and coverage of the Medicare program to ensure that it actually meets the health care needs of the population it is intended to serve.

New Policy G.4.2. Financing mechanisms, such as pooled funding or cross subsidization, that equitably distribute, manage and reduce the risk of caring for those unable to pay for care and that involve payers, purchasers, providers and patients should be established on a statewide basis.

Since the 1960s, Medicare and Medicaid have tried to fill the void for those unable to pay for their care. Philanthropic contributions and a part of private insurance payments have contributed to coverage of these costs. However, Medicare and Medicaid have not covered people who fall through the cracks. Third party payer discounts (contractual allowances), tightened controls by self-insured employers, cost containment pressures and the trend away from inpatient hospital care have contributed to a reduced pool of funds available to underwrite the care of those unable to pay. This has placed significant financial pressures on providers, particularly hospitals, who provide longer amounts of care to those unable to pay.

A variety of financing mechanisms have been initiated in various states across the country to try equitably to cover the costs of care for those unable to pay. To date, most have been limited to hospital payments. Essentially, with this approach money from providers and third party payers is pooled and distributed to those providers based upon the amount of indigent care rendered. Those providers giving the greatest amount of indigent care receive the greatest amount of reimbursement. This approach has been under discussion in Michigan, with an early discussion draft, "Proposal for Financing Health Care for the Poor," set forth by the Greater Detroit Area Health Council (GDAHC). As embodied in that proposal, a trust fund would be developed which would be used to finance health care services for uninsured

New Policy H.1.5.: Third party payers should offer financial support and incentives to encourage families, friends or others to offer support for people at home.

One of the barriers which can discourage families, friends or others from serving in this supportive role is the significant and sometimes overwhelming drain on financial resources. Even when people are willing and able to provide support at home, the financial burden can become too great to continue over a longer period of time. Depending on the needs of the person and the level of financial resources available, some additional financial support could make the difference between caring for the person in the community and institutionalization. The extremely limited availability of and reimbursement for respite care, day care and other support services also limits the development of support for people at home. This policy relates to HSP policies calling for reimbursement which better recognizes and encourages less intense levels of care in all acceptable settings (H.2.1.) as well as those policies supporting community wide patient assessment and coordinating case (care) management systems (H.2.4., T.2. and T.2.1.).

FINANCING OF COMMUNITY - BASED CARE

Goal H.2. Systems of health care reimbursement by government programs and private insurers which promote use of preventive community and home-based services by one or both of these two means:

- -coverage of a full range of services at a similar proportion of total cost or with similar deductible amounts;
- -reimbursement which provides benefits to providers and consumers when sound preventive practices are followed.

Health financing has played a major role in establishing patterns of health care services and will continue to do so. Use of financing to promote preventive, primary and home-based care is of central importance in helping to implement the theme of the HSP. Experience has shown that there is more effective use of resources with insurance coverage of a broader range of services and financial incentives for more efficient methods of providing care. However, only limited financial incentives now exist to promote the early intervention and use of preventive and primary care which can forestall more serious illness. For example, many health insurance plans cover primary care or home care visits only as an option with a deductible amount that the patient must pay, but provide for the full costs of expensive hospital care. As a result, many patients receive care at a level more intensive than they need. (See also Goal T.11. and Policy A.7.2.).

Policy H.2.1. Third-party payers should reimburse for services at all levels of care and for care in all acceptable settings in a similar way, so that choice of level and setting is not influenced by whether it will be reimbursable.

This policy refers to reimbursement for various types of services, not to what appears to be the same service when delivered by personnel with very different levels of training. It does not call for the same reimbursement for service when rendered by a physician assistant as by the physician, but it would say at the same proportion of reasonable value as are those of the physician. The policy does not mean that 100% of every level of care should be covered, but rather that levels of reimbursement should not be so different as to discourage use of less intensive levels of care. Since less intensive, and usually less expensive, levels of health care services are not fully reimbursable under existing financing systems, incentives currently exist to maintain a higher than necessary level of care simply to ensure that patients' costs will be reimbursed. Although changes have been made, additional expansion of services covered by reimbursement is needed to include services which help maintain and promote good health.

Policy H.2.4. Third-party payers should reimburse for uniform, community-wide patient assessment and coordinating case management mechanisms.

Reimbursement for community-wide patient assessment and coordinating case (care) management mechanisms would stimulate their development. See discussion under category T.2. Long-Term Care Systems.

New Policy H.2.5. Third party payers, including Medicaid and Medicare, should reassess and expand their coverage to include relatively small items which currently are not reimbursed but would eliminate barriers which prevent people with limited resources from following prescribed treatments.

Because some items and short-term treatments are sometimes not covered by Medicaid, Medicare and other third party payers, people with limited financial resources are often unable to follow through on treatment of diagnosed health conditions. This frequently leads to continued poor health or more serious and costly health conditions. Eliminating these barriers can result in improved access and probably reduce costs in the long run. Examples include medications, glasses, and treatments.

New Policy H.2.6. Medicare, Medicaid and other third party payers should develop systems that encourage the provision of care to those unable or with limited ability to pay.

Perceived and actual "bureaucratic" red tape, limited payment and other problems exist as access barriers to care for people on governmental programs. While most physicians and other providers should be able to provide some free care to those unable to pay, the number which an individual provider can handle is somewhat limited. Incentives which would encourage providers to increase their volume of Medicare, Medicaid and charity care patients could help reduce these access barriers. One such program, the Physician Primary Sponsor Plan (Medicaid), Wayne County, Michigan, met with mixed success.

Other examples might include:
(1) incentives for physicians who accept new or increase their proportion of Medicare or Medicaid payments
(2) tax incentives based on levels of charity care documented by for-profit providers
(3) increased payment levels by "X"% based on increasing levels of charity care given by non-profit organizations

New Policy H.2.7. Homestead property should continue to be exempt from inclusion in determination of Medicaid eligibility so as to allow the patient's return home if the patient's health condition and support care or services in the home allow.

Without this exemption, patients could lose their homesteads and be without a place to return to if they are well enough and have the necessary support system available to assist them in living as independently as possible. Development of needed support services is called for under other HSP goals (H.1., T.2.).

New Policy H.2.8. All private insurers should offer Medicare supplementary insurance coverage.

New Policy H.2.9. Third party payers should have policies and procedures which require preadmission screening to be done and emphasize patient education and advocacy in order to keep costs down. Resulting cost savings can contribute to the costs of care for those unable to pay.

Through the existence of policies promoting preadmission screening and patient education and advocacy, third party payers can strengthen the trend toward more use of cost effective community services. Required testing done before a needed hospital admission can reduce costs of hospitalization. Increased consumer knowledge and advocacy support can help the consumer use available benefits more effectively.

FINANCIAL ACCESS TO HEALTH CARE (Revised)

Goal P.5. (Revised) No one is kept from using needed and appropriate health care because of limited income. A financial barrier to care exists if medical and dental costs exceed 15% of a person's non-subsistence income. Needed and appropriate health care means:

-least intensive and costly care necessary to treat a diagnosed health status' condition;

-up-to-date care which is scientifically accepted as being effective and safe

Medical and dental costs mean:

-the employee's average contributions to health insurance;

-plus average out-of-pocket medical and dental expenses.

Non-subsistence income means:

-average income;

-minus the poverty-level income figure established by the Federal government.

The goal calls for access to basic (primary) and specialized health care, regardless of income. It does not say that this care should be free for those who have a decent income, but it does say that no one should have to pay more to get care if they have already gone over the "ceiling" of total payments for medical and dental care set in the goal.

That ceiling derived from the Michigan State Health Plan. It assumes that out of the income that you could have and still be defined as poor, you should not have to pay anything for health care. That amount in 1984 was $10,200 for a family of four and $4,980 for a single person. This is similar to the graduated income tax, in which the first $10,200 would be free of tax. Of any income over and above the poverty level, you should only have to pay 15% for medical and dental care.

The 1983-87 Michigan State Health Plan defines health expenditures as including the employer's contribution to the cost of health insurance. The WMHSA has revised the goal to not count this part of the insurance cost, because it is not one which strains the employee's budget. As a result, it does not create a financial barrier to access to health care. In fact, when the employer's contribution is counted as both a health expenditure and as part of the individual's income, the insured person would reach the 15% level with less out-of-pocket expense than would an uninsured person with the same cash income. Thus, it appears to be more equitable to phrase the goal without counting the employer insurance contribution.

It should also be noted that this guideline, 15% of non-subsistence income, is similar to the federal income tax guideline for deductibility of medical expenses for those with incomes modestly above the poverty guideline (in 1984, a family of four with adjusted gross income of $13,300 would be able to deduct medical and employee health insurance expenses above $465.00; this would be the same amount allowed under the financial access guideline in Goal P.5.).

Recent federal rules changes have relaxed some of the technical reporting requirements, but still require the obligated organizations to be in "substantial compliance" with program requirements. Because public funds were used and participating organizations play an important role in meeting the community's health care needs, they should continue to meet their previously agreed upon responsibilities. In order to insure proper accountability to the public these organizations serve, an adequate reporting and auditing system which assures compliance should be maintained.

Hem Policy P.5.5. Third party payers should include coverage in their policies for appropriate and needed care for catastrophic illnesses or injuries which would otherwise represent a major barrier to such care and threaten the financial livelihood of individuals and families. For those not covered by insurance, the federal government should ensure that financing mechanisms for catastrophic coverage are developed. One option would be for a pooled funding mechanism to cover catastrophic care in either or both cases.

In recent years, the awareness of the American public has been raised about the devastating impact a major illness or injury can have on individuals and families. Discussions have begun and proposals have been made concerning the need for and development of some kind of financial coverage to protect people against such catastrophies. Currently, if a person is employed, many commercial insurances cover the costs of major and longer term injuries, such as on the job accidents and brain injured or ventilator-dependent patients. Other types of procedures which still may be considered experimental, such as liver or pancreas transplants or artificial heart implants, usually are not covered. Even in areas not considered such a high technology area, older people and their families experience financial catastrophies in paying for nursing home care after they find out that Medicare pays for very little and their resources are reduced to the point at which the patient is eligible for Medicaid. While ethical issues of who should be treated, who should be allowed to die and who should pay are always involved, the policy calls for the development of some type of catastrophic insurance program by both the private and public sectors so that all people are covered against such devastating consequences of an illness or injury.

Hem Policy P.5.6. Through implementation of procedures and practices which increase efficiency and reduce costs, hospitals, other providers and third party payers should allocate part of the savings covering the cost of care for those unable to pay.

This policy simply suggests that some of the savings achieved through good management decisions should be allocated to pay for care for those unable to pay. Charity care is an obligation which hospitals and other health care providers have as an integral part of their service to their communities.

Hem Policy P.5.7. The "spend down rule" for Group II Medicaid recipients (medically needy) serves as a barrier to health care and should be reduced from six months to one month.

In 1984, a federal judge in Boston held that Massachusetts' use of a six-month spenddown violated the federal Medicaid statute. As a result, medically needy applicants and recipients in Massachusetts are subject to a one-month spenddown rule. The court declared the rule requires states to use the "same methodology" in its Medicaid eligibility determinations as is used in SSI. Since only a one-month budgeting period is employed in the SSI program, the state was required to use the same period for calculating Medicaid eligibility. The court rejected the state's contention that the budgeting procedure was "distinct from the methodology of determining income." The court relied heavily on legislative history to demonstrate the congressional intent to maintain the comparability requirement.

MILTON W. WHITE, M. D., F.I.C.S.
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DETROIT, MICHIGAN 48234
TW 3-2400

July 10, 1987

Donald W. Riegle, Jr.
United States Senator
Federal Building
477 Michigan Ave.
Detroit, MI 48226

Dear Senator:

I received your letter dated July 1, 1987, requesting an opinion about the catastrophic health problem in the insured and underinsured individual.

I assume that with reference to "catastrophic health care problem" you must be alluding to the Medicare or elderly patient.

The younger individual who has coverage with Blue Cross-Blue Shield or other such group insurances have minimal or no problem in receiving the kind of hospital care that they are entitled to get.

It is the elderly, because of the DRG method of payment per illness that is contributing to the most painful and sickening methods of medical care. It is this method whereby a time factor is the guide for therapy regardless of the acuteness, complications, or safety of the ill patient at the time of the alloted, permitted days.

I am a member of the Board of Trustee of the North Detroit General Hospital. I can state that this hospital, because of its compassionate nature will not force the elderly sick patients to be transferred out to a convalescent or extended care unit until the attending doctor will permit such a transfer. In so doing, the hospital has lost close to 1,000,000 dollars in the past nine months.

North Detroit General Hospital is a local hospital bordering the cities of Detroit and Hamtramck. It has no source of funds or foundations. In essence, it cannot afford to subsidize the responsibility that belongs to the U.S. government.

If this is continued to prevail, you will see a rapid destruction of all good dedicated type of medical care that the elderly should have and should be entitled.

The term catastrophic problem and catastrophic health care insurance, though it may sound attractive but unless the catastrophic is clearly defined as good medical care, it may never solve the problem in the elderly. Though a patient may not be catastrophically ill, the elderly, because of his or her age, cannot recover as readily as a younger patient might. It is nevertheless incumbent upon the medical team, insurance, or government to provide the proper care until that individual can be safely and harmlessly transferred home or to an extended care facility.

It is necessary, I believe, to return to the compassionate, and tender care that all doctors, including the U.S. government, must reestablish in caring for the elderly. A return to total insurance coverage for all citizens regardless of age is an absolute must.

There is another concern that you should be alerted to and that is the current medical malpractice crisis. The generation of excellent medical care, the proper form of doctor/patient relationship that has existed for the past century, is now in danger of being destroyed.

I have written a manuscript describing the malpractice problem clearly, factually, and concisely, as it exists today for the solo medical practioner.

Enclosed please find the arcticle entitled "Medical Malpractice or a Permissible Legal Form of Extortion" for your review.

Though the term of "extortion" may sound harsh, it is nevertheless a factual or realistic evaluation for the reason contributing to the avalanche of medical malpractice suits.

Trial lawyers are well aware of the fear element that all solo medical practitioners will have to face if they opt for a layperson jury trial. The possibility of losing one's life savings is too hazardous to chance such a trial. The ultimate in the majority of cases, almost 98% is to agree to a settlement.

This ultimate ending to all suits is certainly a neat form of income not only for the plaintiff, but certainly for the plaintiff's attorney as well, particulary those working on a contingency basis.

This arcticle is not intended to be anti-lawyer. It is, however, against the immorality of the legal system of justice in the State of Michigan, for example that permits the fundamental protection and equal rights for all individuals that the Constitution of the United States guarantees, to elude that status for the solo medical practioner. This arcticle will outline the reasons why!

The legal system of justice must be pursuaded to recognize that the fundamental rights and equal protection of all individuals should certainly include the professional medical practioner as well.

Sincerely,

Milton W. White,M.D.,
F.I.C.S.

MWW:sp
Enclosure

cc: file

MEDICAL MALPRACTICE OR A PERMISSIBLE LEGAL FORM OF EXTORTION

Milton W. White, M.D., F.I.C.S.

Somewhere, somehow there has to be enough judges, attorneys, and legislatures of good conscience, insulated from political pressures and uninfluenced by potential monetary windfall, who should recognise and then exert an effort to correct a legal injustice that currently confronts the individual medical practitioner.

The vast majority of the malpractice suits represent an incongruous distortion of the legal sense of justice. Hopefully our judges, attorneys and legislatures will address themselves to this distasteful if not immoral type of legal tactics.

The constitution of the United States guarantees the fundamental protection and equal rights for all individuals, regardless of race, religion, sex, profession or financial status.

This equal rights and fundamental protection eludes the solo medical practitioner, as I intend to clearly define.

A malpractice suit once started, regardless of its actual merit, nuisance, or maloccurrence reasons, carries a stigmatizing accusation indicating that there has been a dereliction from proper professional care, a failure to exercise an accepted degree of care, or acts contributing to an injurious, negligent or improper therapy. Furthermore, the subpoena permits additional libelous reference as to the integrity, competency and/or good name of the accused physician. If the hospital, although not directly involved with the alleged malpractice act is also being sued, there is then further maligning of the medical practitioner's reputation with the libelous statement that the hospital is derelict for permitting such an "incompetent" physician to treat medical or surgical cases within its confines.

It is true that there are a number of improper or serious medical and/or surgical procedures performed by some medical practitioners. It is certainly correct that such

offenders be properly punished or controlled. However, the vast majority of medical practitioners facing the avalanche of malpractice suits are highly motivated physicians, conscientious, competent, honorable, self-respecting, highly trained and equally concerned in providing the best care for their patients. It is this latter predominant group, however, whose character is defamed with slanderous spoken words, or libeled with printed statements who are accused of improper medical or surgical judgment and care, whose reputation is stigmatized. It is this individual who must be given the equal rights and fundamental protection as provided by the constitution of the United States, but does not have access to this decree.

Legal justice demands that such defamation of character be addressed with equal and fair means in court or other facilities whereby such accusations can be either proven or negated. Does our legal system provide such a means as to provide the protection and equal rights for the majority of medical practitioners being sued? The answer is simply "NO". A careful scrutiny of malpractice suits will readily reveal that the majority of them turn out to be a basic form of legal "scare" maneuvering in order to frighten a reluctant solo practitioner to agree to a settlement, despite feeling not to do so. From the first day of the suit, the practitioner readily becomes aware that in facing a jury of six laypersons, ignorant of medical matters, there is a good chance that a medical defendant could lose a substantial or total amount of one's life savings that might be awarded in a verdict. This award may be markedly above the limits of the existing medical liability coverage, sometimes reaching sums of $1,000,000 to $6,000,000 or more.

The legal question remains, can any individual in a profession as a solo medical practitioner have any degree of protection from the loss of one's savings, where there might be either an omission or comission of some medical judgment? In this current system, obviously not! This is the element of fear that exists for the individual medical practitioner of which the trial attorneys are well aware. Of course an unpredictable jury may turn against the plaintiff. This is not what the plaintiff's attorney wants either.

Therefore, settlement is a good form of income the easy way, and many trial attorneys concentrate toward this end.

Settlements, whether by "scare" or arbitration reasons, in medical matters, are not representative of equal rights and protection for the medical practitioner. These measures suggest a legal manipulation of the sense of justice because although money exchanges hands and the plaintiff and plaintiff's attorney are pleased, the practitioner, however, remains silently condemned while the slanderous and libelous accusations are unreconciled.

This form of "scare" maneuvering in a medical malpractice suit may be synonymously compared to the "greenmail" pattern of the stockmarket entrepreneur. Though the latter is legal, it is still a "scare" technique. The officers of the threatened takeover corporation, fearful of losing control, will buy out the stocks of the entrepreneur at an over-inflated price. This "scare" or "fright" technique exists in the current avalanche of medical malpractice suits, but the fear is in the possible loss of one's life savings. Talk to any solo medical practitioner who has been sued, one who is currently being sued, or even the many who have never been sued. All of these individuals have or have had one common basic "fear" or "fright". This fear exists not only for the possible loss of prestige or honor, but primarily as stated previously with the prospects of facing a jury, consisting of six laypersons influenced by an opposing medical opinion provided by a paid physician, influenced by a vague public opinion that all doctors are rich, or simply influenced by sympathy for the plaintiff's pain and suffering, justified or not, that these jurors may then award dollars of such excess, that the solo practitioner could lose a substantial or the entire amount of one's life savings.

There are, on the other hand, plaintiff's attorneys who do not wish to settle, and will opt for a jury trial. The circumstances of the medical case being such as a death, a maloccurrence, etc., provides a good possibility for a jury award to be larger than the current limit of the liability coverage. Talk again to any solo practitioner who had to

face such a court trial. There was the loss of three to four weeks of office or hospital work and income. There were three to four weeks of a tortuous, hostile, and trick cross examinations. There were sleepless and restless nights. Emotional as well as physical breakdown or complications may have readily developed. And above all the living with constant turmoil within, "what if the award is beyond one's capability of surviving financially". Such experiences, whether the outcome is won or lost, can be disastrous to the well being of the sued practitioner. It may take months and years for the practitioner to recover from such an ordeal. It does not take long for other practitioners who are facing a suit, or ones who may face a suit, to react with fear over the thought of facing such a painful and frightening experience.

If the potential loss not only of part or all of one's life savings, or of an emotional or physical breakdown from a lengthy court procedure for the medical practitioner, is not a "fright" or "scare" position to be in, then our judges or others in the legal system are either blind or are purposely ignoring for political or other reasons, the validity of such fears.

I cannot believe that men or women of good will and conscience, cannot be aware of such anxieties facing the medical practitioners. I feel that if judges, attorneys, or legislatures could imagine themselves in such a position whereby because of a frivolous suit, or even a mistake in their professional judgment that therefore they themselves would be in jeopardy of losing part or all of their life's savings and the protection of their estate and loved ones, I am certain that enlightenment would soon develop and such legal but immoral "scare" maneuvering would soon be eliminated.

In addition to the "scare" tactic, of our current medical malpractice suits, there are a number of other reasons to clearly define the incongruous distortion of the legal sense of justice and the inequality of rights and protection that exists for the solo practitioner. They are outlined as follows:

I. CONTINGENCY FEE

It takes $35 to $45 to start a suit. This is the maximum cost and certainly no risk for the plaintiff.

All malpractice suits with no exceptions are accepted upon a contingency fee basis. The trial attorney states this is necessary so that legal access is available to all those unable to afford it. With such preponderance of suits it is unlikely that every plaintiff is so poor that their only means is by the contingency way. The truth is more likely that with a contingency fee, the attorney can earn or share a higher percentage of the settlement or awarded fee.

The defendant however does not have the privilege of a contingency fee. The medical practitioner must not only bare the burden of proving one's innocence of wrong doing, but must also assume the financial costs for the defense, either by the expenditure of one's own savings or upon funds from the liability insurance company. In consequence there is usually an eventual increase in future liability premiums.

For the plaintiff there is minimal to no cost and certainly no risk in starting a suit. Neither is there a major cost nor a risk for the plaintiff's attorney. The unequal rights and protection applies only to the medical practitioner in the costs of his or her defense, and the frightening possibility of sustaining a substantial financial loss if an unfavorable decision is ultimately made.

II. COUNTER SUIT

A medical practitioner after undergoing an emotional, painful and exhausting trial of three to four weeks, and suffering a loss of income, may fortunately be found innocent of any medical impropriety. This individual may now want to counter sue for loss of income, pain and suffering from a suit that was frivolous and ungrounded. Can he or she countersue? The answer is no! Any individual, except for the medical practitioner, even when such suits have no merit may sue as long as there is a willing attorney. This equal right is not given to the medical practitioner unless it can be proven that fraud was

involved. This is usually an almost impossible claim to sustain.

Counter suits have been attempted only to be dismissed. The supreme court for the State of Michigan, for example, laid down the rule that an attorney cannot be charged with malpractice when he or she files an ungrounded or frivolous suit. This the court states would have a chilling affect on access to the courts for a plaintiff. A strange decree indeed. Apparently it is satisfactory for the accusor to have access to the court, but the accused, however, being a solo medical practitioner, cannot have the same access. Equal rights? Where and why in the name of justice does it stop short for the medical practitioner?

III. I HAVE A MEDICAL DEGREE, WILL TRAVEL

Several years ago there was a television program with the title, "Have gun, will travel". In this world of play acting the star was a man with a gun for hire. For so many dollars he would travel and carry out whatever procedure was required with the use of his gun.

In real life we now have doctors with a medical degree who are for hire for a satisfactory stipend provided by the plaintiff's attorney. This practitioner will readily write or travel to present an opinion calculated to be in conflict or in variance as to what the defending doctor did, did not do, or should have done!

Of all travesty of injustice this for hire medical mercenary is the most dastardly.

I have been a physician for over 45 years. I have attended hundreds of medical meetings and programs during this interval. Seldom was there an educational program whereby a number of top professional educators and teachers of the medical sciences, who didn't present differences of opinion or variable views as to what should be done or not done about the diseases or illnesses under discussion. In the field of medicine this is a healthy contribution. Either side can properly express differences of opinions as to a method of therapy for a particular illness, yet either side can meet the proper standard of care. It is through such scientific discussion that tremendous progress has been made

in the field of medical and surgical care.

A differences of opinion expressed by one physician cannot and must not be accepted as a basis for a malpractice suit award, especially if such a difference is expressed by a paid medical doctor.

IV. PRETRIAL MEDIATION PANEL.

Prior to a court procedure, the Michigan State Court System mandates that three attorneys sit and mediate the set of circumstances involved with the particular in the bill of complaint.

The plaintiff's attorney presents the reason or reasons for the suit and also includes the testimony of a paid physician.

The defending attorney on the other hand may refute the testimony presented by the plaintiff's attorney and will include information solicited by another physician.

But what a strange method to provide legal justice for a medical suit. In this setting there are thus five attorneys, with a limited knowledge of medical facts, who now will evaluate the presentation of medical statements or misstatements. Though attorneys may be highly intelligent and knowledgeable in legal matters, they are nonetheless inadequately trained medically to judge complex medical illnesses or problems. Lawyers cannot conclude accurately or concisely the factual truth about the fault or no fault of the particular case based upon the conflicting differences of opinions or variables as presented by either side.

It takes a student four years of study in a medical school and two to six years of resident training to become a knowledgeable physician. There is afterwards a lifetime of constant review of medical matters and educational programs that become part of a daily source of informed knowledge to the medical practitioner.

Lawyers on the other hand, unless they are also medical graduates, cannot possibly have the knowledge to properly evaluate the factual scientific reasons for the illness or complications involved. Instead they see primarily the pain and suffering of the

plaintiff. Or if there is a death, the empathy developed over the distress of a member of the family involved in the suit. The ultimate solution by such a panel is a mediation to settle the case by recommending the award of so many dollars.

Certainly we must have sympathy and respect for the pain and suffering of an ill patient. Certainly we suffer distress also when a patient under our care dies. However, the doctor cannot be held responsible for such pain and suffering particularly if it is more likely due to the natural consequences of the disease itself.

Mediation and settlement is not justice! It violates the very essence of equal rights and protection that is due to the medical practitioner. Lawyers should have no right to mediate complex medical problems, nor a right to allocate dollars to compensate for the pain and suffering of the plaintiff. It is illness, pain and suffering that brings the patient to the doctor in the first place. Pain and suffering can more likely be the fault of the disease and not solely the physician's. If society demands that those who are ill and those who suffer pain or maloccurrence should be paid a premium, then society should assume that burden. Certainly if sympathy is the basis for such substantial awards the trial attorney should not share an equal portion since he or she had no pain nor suffering.

V. SIX LAYPERSONS

The current legal court procedure which allows six laypersons who are totally ignorant of medical knowledge, who are unqualified to correctly evaluate conflicting complex medical opinions, as presented by opposing sides, yet are given complete authoritative power to sit, evaluate and judge such specialized matters, represents a decided travesty of the legal meaning of justice.

The jury system usually consisting of twelve persons, selected from the local citizenry, has been the strength of our country, through the years, in protecting the democratic principles of equal rights for all human beings.

However, the constitution did not mean that laypersons, sitting as jurors, with their

limited, if any, medical background or expertise, confused by conflicting medical testimonies, should have the power to avoid or ignore the rights and fundamental protection of the individual medical practitioner that should prevail. And the constitution certainly didn't intend that these laypersons should have the immoral authority and capability to destroy the welfare and security of the defendant.

The rights of a medical practitioner, as guaranteed by the constitution demands that he or she be properly judged or evaluated by peers of equal or superior education or knowledge. That judgment should be based specifically upon the merit or lack of merit for the basis of the suit.

Medical practitioners, as a group, are not criminals and certainly not individuals who deliberately or carelessly contrive to cause damage or increased pain and suffering to those under their medical care.

Yet it seems strange that medical practitioners, who are members of a profession that is universally held in the highest of esteem, are presently being treated as criminals. In today's court system the medical practitioner must face laypersons who can readily be influenced by an opposite point of opinion as to what should have been done or not done by a paid physician, or who cannot properly evaluate the statements or mistatements as cunningly presented by the plaintiff's attorney, or who may have sympathy for the pain and suffering or deformity of the plaintiff, or simply with the attitude that all doctors are rich. Yet these same laypersons, totally ignorant of medical knowledge, maintain the full legal authority to award such large sums of money as to financially ruin the welfare and security of the defendant.

Laypersons are not qualified to evaluate an opinion, as presented by a paid physician, and still render a proper and just judgment. One of the least justifications for a fair analysis of the malpractice suit is to rely on a variable opinion as presented by one physician, especially by one who is hired for pay so as to provide such an opposing view.

Illness, pain, suffering, complications and eventually death is the ultimate fate for all human beings. Babies can be born with birth defects. Certain individuals will die in their younger years due to their own abuse with alcohol, cigarettes or drugs. Others will have severe complications from natural causes as diabetes, cancer, hypertension, cardiac failure, AIDS, or other serious diseases! There can be no guarantee that such maladies, even if treated in a like manner by all physicians to have 100% cures, to avoid the occurence of complications, or even to prevent the ultimate death of such ill patients.

Medical practitioners enter this profession with the attitude to provide good health for the ill, to avoid complications from the natural causes, and to prevent death if at all possible. Their dedication is not to injure but to remove suffering whenever or wherever possible.

There are a multitude number of organs in a human being. In illness, one, several or all of the organs may become diseased and progressively worsen with the passage of time. Treatment given by physicians because of the multiple factors involved, in any major illness, or even in some minor ones, may vary and differences of opinion will occur as to the method of treatment that is best for the patient. Such variables, views or differences of opinions do not necessarily mean that only one method is proper and all others incorrect.

Variable views and differences of opinion, because of the complexities of medical illnesses, and because medicine is not a definite exact science, are constantly present. In treating seriously ill patients, it is up to the judgment of each practitioner and consultant as to the best direction to follow for that particular problem. Because of the vast complexities involved in the medically or surgically treated illnesses, there can be no guarantees for total cure, absence of complications, or even avoidance of death.

If justice is to be served, only a select group, six in number, of unbiased medical practitioners should be allowed to judge a malpractice claim. This may certainly be less biased then mediation or evaluation by attorneys or laypersons. An opposing point of view

by one physician cannot and must not be accepted carte blanche as a sound statement of fact.

If complications do occur and in sympathy one must award such a patient or estate sums of money, then let there be a public fund whereby such amount as evaluated by a judge could be distributed.

If this permissiveness of uncontrolled suits are permitted to continue, there will be a slow desertion of our highly motivated solo practitioners from the practice of medicine. Instead there will be only corporate practitioners or eventually socialized medicine. If the latter develops, suits will stop dramatically because the government will then be the employer.

A layperson court procedure against a medical practitioner in a malpractice suit, with their sympathetic attitude to award large sums of money in favor of a plaintiff at the financial expense of the defendant, is indeed a frightening experience. If this procedure is not tantamount to a permissible legal form of extortion, it certainly represents a means to "frighten" or "scare" most practitioners to settle for so many dollars out of court, in order to avoid such a possible financial disaster.

With the current medical malpractice suits the equal rights and fundamental protection as guaranteed by our Constitution, for the practitioner, is definitely set aside. If all these legal maneuverings against the medical practitioner, to repeat again, is not considered a form of extortion then it certainly represents a form of legal distortion of the sense of justice for the medical practitioner.

It is true there are a number of medical or surgical physicians who are incompetent or impaired. These individuals must be stopped and/or removed from the profession. The majority of practitioners, however, deserve to be judged, as citizens of this country, with dignity and proper rights.

Somehow, somewhere judges, attorneys, and legislators of good conscience must recognize this injustice and exert an effort to correct this immoral situation that confronts the individual medical practitioner currently.

NORTH DETROIT GENERAL HOSPITAL

JULY 10, 1987

DEPARTMENT OF MEDICINE AGENDA

I. **CALL TO ORDER**

II. **OLD BUSINESS**

A) Review of 6/12/87 minutes - attached

B) Other old business

III. **NEW BUSINESS**

IV. **ADJOURNMENT**

****THE NEXT DEPARTMENT OF MEDICINE MEETING WILL BE HELD ON FRIDAY, SEPTEMBER 11, 1987 at 9 A.M.****

NORTH DETROIT GENERAL HOSPITAL

MEDICAL STAFF COMMITTEE MINUTES

DATE: JUNE 12, 1987

TIME CALLED TO ORDER: 9:15 a.m.

TIME ADJOURNED: 10 a.m.

MEMBERS PRESENT: Drs. Alfonso, Alshab, Amalfitano, Andrushkiw, Barfi, Batmanghelichi, Edmond, Enfroy, Gaba, Ginsberg, Goknar, E. Goldberg, Hughes-Bessette, Johnston, Kaufman, Latif, Levy, Malinowski, Meier, Muesing, Nanes, Parejo, Ramirez, Ramos, Rey, Schock, D. Shah, Shiovitz, Velilla, C. Weiss, White, del Valle, Greenberg, Haking, Suwinski

MEMBERS ABSENT: See attached sign-in sheet

COMMITTEE: DEPARTMENT OF MEDICINE

AGENDA	DISCUSSION	ACTION TAKEN	RESPONSIBLE PARTY
1) Minutes of 5/8/87	The minutes of the previous meeting held 5/8/87 were reviewed.	Minutes of 5/8/87 accepted.	
2) Day Treatment Center	Dr. Goknar invited all physicians to visit the new Day Treatment Center located at 3002 Carpenter. The Center is now open and services are available for staff referrals.	Staff members invited to visit Day Treatment Center.	
3) Election of Chief of Medicine	At the June 5, 1987 Quarterly Staff Meeting it was decided that elections for Department chiefs would be held at the June Departmental meetings. The Bylaws state that each department shall choose a member of the department to serve as department chief. The name shall then be submitted to the Board for approval. There was a discussion regarding the election procedure. Dr. Martin Schock was then nominated. No other nominations were made.	Dr. Martin Schock was re-elected as the Chief of Medicine by acclamation.	BOARD OF TRUSTEES
4) AIDS cases	Dr. Schock reported on a recent brochure from the Department of Public Health regarding handling AIDS testing and patients. A) Any patient can have the HTLVIII test done by the Department of Public Health at no charge and with complete anonymity. B) If the private physician is doing an HTLVIII test on a patient, he is obligated to obtain an informed consent from the patient and to discuss the possible results of the test.	Suggested that the Hospital develop a policy on handling AIDS patients based on the information fromm the Department of Public Health.	EXECUTIVE COUNCIL

DATE_____ COMMITTEE CHAIRMAN_____

AGENDA	DISCUSSION	ACTION TAKEN	RESPONSIBLE PARTY
4) AIDS cases (continued)	C) No patient should receive the HTLVIII test at a facility where counselling is not available. It was also mentioned that routine testing cannot be required. There was some discussion regarding the autotransfusion program.		